Salem Health and Salem Health West Valley
Financial Assistance/Charity Care Administrative (Condensed) Policy and Application

Salem Health is committed to ensuring our patients get the hospital care they need regardless of ability to pay for that care. Providing health care to those who cannot afford to pay is part of our mission and we provide free and discounted care to eligible patients. You may qualify for free or discounted care based on your family size and income, even if you have health insurance. You may also be eligible for other government and community programs. We can help you learn whether these programs (including Oregon Health Plan) can help cover your medical bills and assist you in applying for these programs.

What is Covered? We provide free care and financial assistance to eligible patients on a sliding fee scale basis, with discounts ranging from 65% to 100%, for emergency and other appropriate services at Salem Health Hospitals & Clinics. This program only covers medically necessary care provided at Salem Health Hospitals & Clinics. It does not cover any non-medically necessary procedures, prescriptions or physician charges billed outside of Salem Health. A patient who is eligible for financial assistance will not be charged more than amounts generally billed to patients who have insurance.

Applicable Providers: Financial assistance discounts will be applied to any balance(s) owed to Salem Health Hospitals & Clinics or employed providers of the Salem Health Medical Group. Non-employed providers rendering services within our facility are not required to honor our financial assistance determination.

Emergency Care: Salem Health has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Eligibility and Determination: Criteria considered in determining eligibility is based on your family size and household's* gross income.

Household income is based on the annual Federal Poverty Guidelines (FPG) will be eligible for Financial Assistance upon submission of an application as outlined below and in the FPG Financial Matrix:

Financial Assistance Category	Percentage Discount
0-300% Income as a Percentage of Federal Poverty Level	100%
301-400% Income as a Percentage of Federal Poverty Level	65%
Catastrophic Discount	100% of balances greater than 20% Gross Family Income

*The definition of 'household's gross income' includes the combined gross monthly income of all persons legally responsible for patient bill or balance.

You will receive a determination letter or request for additional documents letter in the mail within 21 days after we receive your application. Any other potential sources of payment, such as state medical insurance, health share coop/cost sharing, liability insurance, workman's comp, etc. must be exhausted prior to receiving discounts. Financial assistance is the option of last resort and you must cooperate with the approval process of any funding solution that would pay the patient's bills in order to be eligible for financial assistance.

Financial assistance determinations are valid for 12 months. Coverage will begin with the oldest date of service per the household and end the last day of the twelfth month from which the approval is processed.

How to Apply for Financial Assistance: Any patient may apply by submitting an application and providing supporting documentation. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.
In order for your application to be processed, you must provide:

1. Current year federal tax filing, we need all pages and schedules. If you own a business, please include current year business/corporation taxes. Please do not send hand written taxes, W-2's, or state taxes, as we cannot accept these documents.
   –OR
2. If you did not file a current year tax return, you will need to get a non-filing verification letter from the IRS. You may call the IRS at 1-800-829-1040 to request the letter or visit your local IRS office to request that letter.

If you have income from any of the following, please attach copies to your application.

3. Most recent three (3) months wage stubs from your employer. Do not send direct deposit information or bank statements, as we need to see the gross pay (before taxes and deductions are taken out).
4. Current year Social Security Administration award letter, please do not send bank statements.
5. Current year pension benefit award letter, please do not send bank statements.
6. Veterans Affairs award letter, please do not send bank statements.
7. Annuity award letter, please do not send bank statements.
8. Unemployment benefits letter, please do not send bank statements.
9. Child support award letter, please do not send bank statements.
10. Alimony award letter or court documents.
11. Student financial aid award letter.
12. Short term disability benefits award letter, please do not send bank statements.
13. Long term disability benefits award letter, please do not send bank statements.

If your household does not have any types of income listed above, please contact our office at 503-562-4357 (option #3) to see if you may be eligible for the Oregon Health Plan and we can assist you in applying.

If you have any questions, want to schedule an appointment, or would like further information, please contact us:

- By telephone: 503-562-4357
- Email: financial.counselors@salemhealth.org
- On our website at: http://www.salemhealth.org/financialassistance

Translated versions of the application form, financial assistance policy, and summary, are available upon request in Spanish, Russian and Vietnamese. To obtain documents via mail free of charge, call 503-562-4357, or visit our website.

Please fill out the enclosed application form in its entirety and attach the required documentation listed above, and return to Salem Health, PO Box 14001, Salem, OR 97309. You may also email to financial.counselors@salemhealth.org, fax to 503-814-1998, or drop off in person at the main hospital campus in Building A, 1st floor at the information desk or at West Valley main desk lobby.

Other Discounts and Options:

- **Uninsured discount:** We offer a 53% discount for patients who do not have health insurance coverage.
- **Payment plans:** Any balance for amounts owed by you is due within 30 days. The balance can be paid in any of the following ways: credit card, payment plan, cash, check, or online bill pay.
  - If you need a payment plan, please setup via MyChart or call the number on your billing statement, 503-814-2455.

Salem Health Hospitals & Clinics

Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No**

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional)
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill

□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

Household means: a single individual; or spouses, domestic partners, or a parent and child under 18 years of age, living together; and other individuals for whom a single individual, spouse, domestic partner or parent is financially responsible.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain*_____)

Salem Health Hospitals & Clinics

Charity Care/Financial Assistance Application Form – confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance.
All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.
Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

EXPENSE INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____
Insurance Premiums $_____ Utilities $_____
Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ASSET INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

Current checking account balance
$_____
Current savings account balance
$_____

Does your family have these other assets?
Please check all that apply
□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)
□ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that [*Hospital/system Name]* may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____
Signature of Person Applying Date