Salem Health®
Hospitals & Clinics

To our valued patient,

Salem Health is committed to providing medical care to those patients who may not have sufficient financial resources available. If you qualify for financial assistance, a portion of your account(s), up to 100% may be forgiven. **This program only covers the medically necessary Salem Health facility charges and does not cover any elective procedures, prescriptions, professional and/or physician fees.**

An application for financial assistance is required for Salem Health to make any financial adjustment to your account(s) balance. Please fill out the enclosed form in its entirety and attach the required documentation, then return to Salem Health. **Failure to provide the requested documentation for your household can result in a denial of financial assistance**.

You will receive a determination letter in the mail within 21 days after receiving your completed application. If additional information or documentation is required to process the financial assistance application, you will be informed of those requirements. **Any other potential sources of payment, such as state medical insurance, health share co-op/cost sharing, liability insurance, workman's comp etc.. Must be exhausted prior to adjusting your account(s)**.

Should you have any questions, please contact the Financial Assistance Team at (503) 562-4357. You may visit our office at 550 Hawthorne AVE SE Salem, OR 97301 ***or*** you may fax the completed application and documentation to (503) 814-1998. If you would like to mail the application, use the PO Box listed below. Our e-mail address is financial.counselors@salemhealth.org

Sincerely,

Financial Assistance Team
Salem Health and West Valley Hospital
PO Box 14001
Salem, OR 97309-5014

Family information -List immediate family unit members who are related to you by birth, marriage or legal adoption. -A family unit can consist of a legally married couple living together or apart, an unmarried couple with one or more children in common, domestic partnerships registered with the State of Oregon, and children if they are under 18.
Employment income or other income -Include gross (before taxes) income for the past three calendar months. -Include unearned income from dependent children. For example Social Security income, child support, adoption assistance, student financial aid. -Include income from interest, dividends, bonds, etc...

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Please read carefully

You must provide: Current year Federal Income Tax Return 1040 **or** non-filing verification letter from the IRS

And all that apply: ___Last 3 calendar months pay check stubs for self and spouse/domestic partner

___Current year SSI/SSA/SSD award letter ___VA award letter ___Pension _____Annuity

___If you report $0 income, please complete and sign the attached affidavit

Patient Financial Assistance Application

Patient Name: _____ Date of birth: _____
Have you applied for Oregon Health Plan (Medicaid)? Yes ___ When? _____ No_____
Are you part of a health share co-op/cost sharing program? Yes ___ No___

Responsible person

Name _____Date of birth_____ Phone #_____
Street Address: _____City _____State ____ Zip_____
Employer: _____How long? _____ Gross Monthly Income $_____
Other income source _____ Monthly amount $_____

Spouse/Domestic partner

Name _____ Date of birth_____ Phone #_____
Employer: _____How long? _____Gross Monthly Income $_____
Other income source _____ Monthly amount $_____

Children

Name _____Date of birth_____ Relationship _____

Name _____Date of birth_____ Relationship _____

Name _____Date of birth_____ Relationship _____

Name _____Date of birth_____ Relationship _____

Medical expenses (other than insurance premiums)*We may request proof of these amounts*
Monthly Medical payment amount $_____ Monthly Pharmacy copay amount $_____
Additional income source: $_____/month *attach proof of this (Rental property, social security, pension, unemployment, etc...)

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services, which are rendered to me by Salem Health. I hereby grant permission to Salem Health to receive, release, or act upon financial information, to investigate the information contained herein. Investigation shall contain contacting, by written communication or telephone, of those persons, firms, corporations, etc… noted by you on this financial information document. Investigation may also include a credit check. I hereby release the designated hospital personnel and all parties who supply information at the request of hospital personnel from liability for any acts of commission or omission, communications or disclosures that are made pursuant to such an investigation. **I understand that submission of false information will automatically disqualify me for any type of assistance**.

Responsible Person Signature: _____Date:_____

Spouse/Domestic Partner Signature: _____Date:_____

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Patient name: _____ Date of Birth: _____

AFFIDAVIT

I, _____ (PRINT NAME), certify that during the following period of time _____ (beginning date) to present, I was without income or resources and received assistance from _____ (name of person or shelter).

I make this certification in application for any financial assistance for which I might be entitled because of my financial situation. I understand that should this certification prove to be false in any material aspect, Salem Health may reverse any financial assistance granted and hold me personally responsible for the charges.

_____ Date _____
Responsible person signature

_____ Date _____
Person assisting patient signature

_____Phone number: _____
Print name