

PORTLAND AREA FINANCIAL ASSISTANCE APPLICATION / SAFETY NET CLINIC

To apply for Financial Assistance at a Portland Area Hospital:

1. Complete this application.
2. Attached copies of: Previous year's tax returns AND verification showing year to date income or last 3 months pay stubs.
3. Submit to Business Office at hospital where care was provided.

GENERAL INFORMATION

Patient's name	Last	First	M.I.	Social Security Number	Date of birth
<input type="checkbox"/> Yes <input type="checkbox"/> No					
U.S. Citizen	Marital status	Spouse's name Last First M.I.			Telephone No. Home / Work
Person responsible for paying the bill		Relationship to patient			Telephone No. Home / Work
Number of people in household		Ages of people in household			
Health insurance coverage (company name, ID#)					

HOUSEHOLD INCOME

	PERSON 1	PERSON 2	PERSON 3
NAME:			
RELATIONSHIP TO PATIENT:			
Monthly gross income (attach verification)	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Unemployment, if so, how long _____	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Social Security, pensions	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Alimony/child support	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Government assistance, food stamps	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Other sources of income	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Checking account balances	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Savings account balances	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Stocks, bonds, IRA's, investments	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>
Other assets	\$ <u> </u>	\$ <u> </u>	\$ <u> </u>

AUTOMOBILE / VEHICLE

	VEHICLE 1	VEHICLE 2	VEHICLE 3	VEHICLE 4
Make / Year				
Monthly payment				
Value				

MONTHLY EXPENSES / BILLS

<input type="checkbox"/> Rent \$ <u> </u>	<input type="checkbox"/> Monthly Mortgage \$ <u> </u>	Mortgage Balance \$ <u> </u>	Equity \$ <u> </u>
Utilities	\$ <u> </u>	Alimony/Child support	\$ <u> </u>
Credit cards (total)	\$ <u> </u>	Health insurance	\$ <u> </u>
Insurance (vehicle/life/property)	\$ <u> </u>	Healthcare bills	\$ <u> </u>
Child care	\$ <u> </u>	Medications	\$ <u> </u>
Living, i.e. gas, food, clothes	\$ <u> </u>	Entertainment	\$ <u> </u>
Other	\$ <u> </u>	Other	\$ <u> </u>

COMMENTS OF EXTENUATING SITUATION (attach another page if needed)

X _____
 Responsible Person's Signature _____
 Date

I certify the information contained above is correct and complete to the best of my knowledge, and may be verified by hospital.

Referring Safety Net Clinic: _____

Safety Net Clinic Contact Name: _____

Oregon Health Plan (OHP)

Patient pre-screened for OHP: Yes No

OHP screener name & phone number: _____

OHP application submitted: Yes No

Status: _____

Actions needed: _____

Comments: _____

*Please staple a copy of OHP application and/or other information relevant
to financial assistance to this form*