900 11th Street S.E. - Bandon, OR 97411
Phone: 541-347-2426 ~ Fax: 541-347-3923

Financial Assistance Application

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

After completing this form, please attach a copy of last year's Federal Income Tax Return as well as the last 3-month's paycheck stubs of the patient or guarantor. All of the information supplied to Southern Coos Hospital is used solely for determining your eligibility for financial assistance through the Financial Assistance Policy at SouthernCoos Hospital for your current medical bills. All information is reviewed and verified before a final determination can be made. If there are any further circumstances that you feel will be helpful in making a determination, please include that information on a separate sheet and attach to this application. This form must be signed by the Primary Wage Earner and spouse, if applicable. All information contained in this form is kept confidential.

<u>*Please remember to supply all information requested. If you are unable to supply all information, please attach an explanation why the information is not available. Missing information may cause your application for Financial Assistance to be denied.</u>**

THE FOLLOWING INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF SOUTHERN COOS HEALTH DISTRICT SEEKS TO VERIFY INFORMATION ON THIS APPLICATION, I AUTHORIZE ANY PARTY CONTACTED BY SOUTHERN COOS HOSPITAL BUSINESS SERVICES PERSONNEL TO RELEASE THE REQUESTED INFORMATION TO THEM. I UNDERSTAND THAT PART OF THE VERIFICATION PROCESS MAY INCLUDE OBTAINING A COPY OF MY CREDIT REPORT.

APPLICANT SIGNATURE:	**DATE:**
SPOUSE SIGNATURE:	**DATE:**

Southern Coos Hospital & Health Center

Financial Assistance Application - **PLEASE PRINT ALL INFORMATION**

FAMILY DATA

Patient Name:	**Phone #:**	**SSN:**	
Primary Wage Earner:	Phone #:	SSN:	

Relationship to Patient:	Who claims patient as a dependent on Federal Taxes:		
Address:	City:	ST:	ZIP:

Are you: Homeless? Yes__ No__ Unemployed? Yes__ No__ Uninsured? Yes__ No__

Names of all persons living in your household. Include dependent children under age 18.

Spouse:	SSN	Date of Birth:						
Name:	Relationship	Age		Gender	M ❒ F ❒	Pregnant	Y ❒ N ❒
Name:	Relationship	Age		Gender	M ❒ F ❒	Pregnant	Y ❒ N ❒
Name:	Relationship	Age		Gender	M ❒ F ❒	Pregnant	Y ❒ N ❒
Name:	Relationship	Age		Gender	M ❒ F ❒	Pregnant	Y ❒ N ❒
Name:	Relationship	Age		Gender	M ❒ F ❒	Pregnant	Y ❒ N ❒

EMPLOYMENT/INCOME DATA - List Earned Income before taxes & deductions for each family member who works.

Name of Working Family Member	**Employer Name & Address**	**Monthly Gross**	**How Often? Weekly/Monthly/Annually**
		$	
		$	

Please supply the most current 3 months of paycheck stubs.

Other income not from an employer. Please supply copy of check or bank statement showing deposits.

Type of Income	**Family Member Receiving Income**	**Amount**	**How Often? Weekly/Monthly/Annually**
Social Security		$	
Railroad Retirement		$	
Veteran's Benefits		$	
IRA's, Investments,Stocks, Bonds		$	
Annuities		$	
Pensions		$	
Child Support		$	
Alimony		$	
Unemployment		$	
Workers Compensation		$	
Rental Income		$	
Trust Income		$	
Government Assistance		$	
Dividend Income		$	
Bank Account Income		$	
Other income, please specify		$	
		$	**TOTAL OF ALL INCOME**

Does your family receive Food Stamps? ___Yes ___No

Does your family qualify for free or reduced cost lunches through the school district? ___Yes ___No

Southern Coos Hospital & Health Center

Financial Assistance Application - PLEASE PRINT ALL INFORMATION

Banking Information - Please list complete information below. Include investment & trust accounts here.

Bank/Credit Union Name	Branch	Account Balance Checking/Savings	
		$	$
		$	$
		$	$

ASSETS (Description of assets and values)		Current Value	Amt. Owing	Equity	Monthly Payment
Primary Residence & Land (current tax assessed value)		$	$	$	$
Additional Property: land, dwelling etc. (current tax assessed value		$	$	$	$
Vehicle 1	Year/Make	$	$	$	$
Vehicle 2	Year/Make	$	$	$	$
Vehicle 3	Year/Make	$	$	$	$
Additional		$	$	$	$
Other Vehicles/Recreational Vehicles/Boats etc.		$	$	$	$

MONTHLY LIVING EXPENSE					Monthly Payment
Home: Own _______ Rent ________ Paid to:					$
Food and non-food necessities					$
Utilities (check all that apply): ___Electricity ___Heat (oil, wood, gas) ___Garbage ___Phone ___Water/Sewer					$
Vehicle Expense: Gas, Oil, General Maintenance					$
Insurance Monthly Premiums not deducted from Pay (check all that apply): ❒ Health ❒ Auto ❒ Life ❒Home					$
Other Miscellaneous Expenses: List individually with the amounts. Child care, school expense, home repair, alimony, child support					$
	$		$		
	$		$		
	$		$	TOTAL MONTHLY LIVING EXPENSES	$

DISCRETIONARY DEBT, CREDITORS AND OTHER MONTHLY PAYMENTS NOT LISTED ABOVE (medical bills, credit cards, loans)

NAME OF CREDITOR	Original Amt.	Balance	Monthly Payment
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
	$	$	$
Please list additional creditors on a separate sheet of paper	**TOTAL OTHER MONTHLY PAYMENTS**	**$**	

Financial Assistance Application - **PLEASE PRINT ALL INFORMATION**

a. Are you seeking Financial Assistance because of a work-related accident or injury.

b. Are you seeking Financial Assistance because of a car accident?
c. Are you a student? Y__ N__ If yes, are you full-time? __ part-time? __

d. Do you have an application pending for any of these programs **(Check all that apply)**
Medicaid / OHP Y__ N__ Medicare Y__ N__

e. Are you currently approved for Financial Assistance at another hospital or community health center? Y__ N__ If yes, where? ____

f. Have you applied for Medical Insurance through the affordable care act (Cover Oregon or any other Health Insurance exchange)? Y___N___ If No, Explain_____________________________________

If you have questions about this application, contact the Financial Counselor at
(541) 347-2426, ext.229.

Mail the completed application to:

Southern Coos Hospital
Financial Assistance Processing
900 11th St. SE
Bandon, OR 97411