Southern Coos Hospital & Health Center

APPLICATION FOR FINANCIAL ASSISTANCE
REQUIRED DOCUMENTATION

In order to process applications for hospital-based assistance, supporting documents must be returned to the Financial Counseling Department within thirty (30) days for the request to be considered.

The following is a list of documents that are required. Send only those documents that apply to your circumstances. Please send **copies**, not originals. Please initial to the left of each item you are sending.

1. Most recent tax return including **ALL SCHEDULES** and must be signed (if E-filed, include copy of E-file signature filing confirmation).
2. Pay stubs for the **past three months**.
3. Social Security Award Letter for current year.
4. Unemployment Compensation Benefit Letter.
5. Food stamp/public assistance award letter.
6. Name and phone number of caseworker (if receiving SNAP benefits or other public assistance.
7. **Complete** checking account statements (all pages) for the **past three months**. This is only needed if you cannot produce all of 1-7 that applies to you.

***** If there are extenuating circumstances that you would like us to take into consideration please include a letter with your application.**

SOUTHERN COOS HOSPITAL & HEALTH CENTER
We're here for life!

Financial Assistance Application – PLEASE PRINT ALL INFORMATION

Applicant Data

Patient Name:	Phone#:	SSN:	Date of Birth:
Address:	City:	State:	Zip:

Are you: **Homeless?** Yes ☐ No ☐ **Unemployed?** Yes ☐ No ☐ **Uninsured?** Yes ☐ No ☐

Family Data - Names of all persons living in your household. Include anyone you claim as dependent on your taxes.

Spouse:	SSN:	Date of Birth:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:
Name:	Relationship:	Age:

Household Income

Income Information – Employment and other income sources & monthly amounts for household members. "Income Source": Name of employer or specific source of income (E.g.: SS, SSDI, Annuity, Pension, etc.)
Note: In absence of income, a letter of support from individuals providing for the patient's basic living needs is required.

Income-All Sources	Employer Name & Address	Monthly Gross	How Often?	Weekly/Monthly/Annually
		$		
		$		
		$		
		$		
		$		

If you do not file taxes, check here: ☐ **Does your family receive food stamps? Yes** ☐ **No** ☐

List additional sources of income on a separate sheet.

Does your family have these other assets? Check all that apply and include copy of a recent statement for each: ☐ Stocks ☐ Bonds ☐ 401K/IRA/Annuity ☐ Health Savings ☐ Trust(s) ☐ Real Estate (excludes primary residence)

Medical Debt (If additional space is needed, please list on a separate sheet of paper.)

Provider/Clinic Name:	Monthly Payment	Balance
	$	$
	$	$
	$	$

Extenuating Circumstances: Attach a separate page explaining any extenuating situation that you would like us to consider in making our determination.

READ CAREFULLY BEFORE SIGNING

I certify that the information in this application is correct and complete to the best of my knowledge and that the information is subject to verification and any means that Southern Coos Hospital and Health Center deems necessary. I understand that intentionally providing false information and/or submission of an incomplete application will result in a denial of my request for Financial Assistance.

Patient Signature: _____ **Date:** _____
(Or Parent/Legal Guardian if patient is a minor)

Spouse Signature: _____ **Date:** _____