



**WILLAMETTE**  
**SURGERY CENTER**  
*Heartfelt, Professional Care*

**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

**Patient Financial Assistance Application**

Patient Name: _____		Date of birth: _____	
<b>Have you applied for Oregon Health Plan (Medicaid)?</b> Yes ___ When? _____ No ___			
<b>Are you part of a health share co-op/cost sharing program?</b> Yes ___ No ___			
<b>Responsible person</b>			
Name _____		Date of birth _____	Phone # _____
Street Address: _____		City _____	State _____ Zip _____
Employer: _____		How long? _____	Gross Monthly Income \$ _____
Other income source _____		Monthly amount \$ _____	
<b>Spouse/Domestic partner</b>			
Name _____		Date of birth _____	Phone # _____
Employer: _____		How long? _____	Gross Monthly Income \$ _____
Other income source: _____		Monthly amount \$ _____	
<b>Children</b>			
Name _____		Date of birth _____	Relationship _____
Name _____		Date of birth _____	Relationship _____
Name _____		Date of birth _____	Relationship _____
Name _____		Date of birth _____	Relationship _____
<p>Medical expenses (other than insurance premiums)*We may request proof of these amounts*          Monthly Medical payment amount \$ _____ Monthly Pharmacy copay amount \$ _____  <b>Additional income source:</b> \$ _____/month *attach proof of this (Rental property, social security, pension, unemployment, etc...)</p>			
<p><b>I certify that all information listed herein is true and correct to the best of my knowledge.</b> 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. <b>I understand that submission of false information will automatically disqualify me for any type of assistance.</b></p>			
Responsible Person Signature: _____		Date: _____	
Spouse/Domestic Partner Signature: _____		Date: _____	