Business Office
Phone: 503-566-3507
Fax: 503-581-4405

Please return form to:
1445 State Street
Salem, OR 97301

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
___Proof of unemployment ___Current year SSI/SSA/SSD award letter ___VA award letter ___Pension ___Annuity

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 Willamette Surgery Center. I hereby grant permission to WSC and 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: _____