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

WILLAMETTE
SURGERY CENTER
Heartfelt, Professional Care

Please return to:
1445 State Street
Salem, OR 97301

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

___If you report $0 income, please complete and sign the attached affidavit

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 $_____

Dependent 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: _____

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If you report $0 income, please complete this page in addition to page 1

Patient name: _____ Date of Birth: _____

AFFIDAVIT

I, _____ (PRINT NAME), certify that during the following period of time _____ (beginning date) to present, I was without income or resources and received assistance from _____ (name of person or shelter).

I make this certification in application for any financial assistance for which I might be entitled because of my financial situation. I understand that should this certification prove to be false in any material aspect, Willamette Surgery Center may reverse any financial assistance granted and hold me personally responsible for the charges.

_____ Date _____
Responsible person signature

_____ Date _____
Person assisting patient signature

_____ Phone number: _____
Print name