

Financial Assistance Application

Tuality Healthcare provides medically necessary healthcare to our community without regard for an individual recipient's ability to pay. If paying your bill presents a financial hardship, partial or full financial assistance may be available to you based on established criteria. Eligibility for assistance is determined through a financial review of the patient or responsible party.

Important Notes

- If financial assistance is approved, it is not a guarantee that services will be provided.
- Not all services are eligible for financial assistance. It is the patient's responsibility to verify in advance whether a requested service is eligible for financial assistance. Excluded services include (but are not limited to):
 - A. Services considered non-covered or not medically necessary by the Oregon Department of Medical Assistance Program (DMAP)/ Oregon Health Plan (OHP);
 - B. Services provided to a patient who chooses to come to Tuality Healthcare out of their insurance plan network;
 - C. Patients who are not responsible for the bill (i.e., Community/Agency funded support);
 - D. Patients who have insurance but choose not to utilize coverage;
 - E. Elective cosmetic surgery procedures;
 - F. Other elective procedures (examples include but are not limited to infertility services, andrology services, transplants, sterilization, (with the exception of in-house postpartum tubal ligation patients), reversal of sterilization, circumcision, LASIK eye surgery, routine vision exam);
 - G. Take home prescriptions or supplies issued by the pharmacy;
 - H. Medical Equipment;
 - I. Providers fees that are not billed through Tuality Healthcare
- You will receive a letter in the mail letting you know if your application was approved.
- Financial assistance is secondary to all other financial resources. If you appear eligible for Medicaid, you will be required to apply.

Instructions for completing financial assistance application

- Print legibly in ink.
- Completed applications and supporting documentation should be returned within 14 days of receipt.
- Incomplete application will not be considered and may be denied. The collections process on outstanding balances continue until complete application has been processed.
- Return completed application and all required supporting documentation to:
 - Tuality Healthcare
 - PO Box 548-Attn: FA
 - Hillsboro, OR 97123
 - Fax: 503-681-1365
- For questions please call 503-681-1012 between 8:00 a.m. to 4:30 p.m. Monday through Friday



TUALITY HEALTHCARE
An OHSU Partner

Financial Assistance Application- Verification Documents

Please send copies of all documents below that apply to your situation. Original documents will not be return.

Residency Verification

- Proof of residency. Accepted documents may include utility bills in your name, a rental agreement, mortgage statement for your residence, or a copy of your driver's license or identification card. Additional proof of residency may be requested depending on individual circumstances.

Income Verification-Include all of the following that apply to your situation

- Paycheck stubs received for the last three fully completed calendar months. If you do not have your paycheck stubs you may instead provide a letter from your employer listing gross income for the last three fully completed calendar months.
- Most current Social Security, Veterans, Pension Award Letter or equivalent
- Most current claims determination from the State Employment Division
- Statement of child support and/or alimony
- Self-Employment Profit/Loss Statement for the last three fully completed calendar months
- Verification documents for any other income source listed on your application, including income from interest or dividends
- Signed letter indicating periods of time with no income

Tax Returns

- Most recent federal tax form (1040, 1040EZ, 1040A)
 - Self-employed: Include Schedule C
 - Rental Property/Corporation/Trust: Include Schedule E

Asset Verification- Include all of the following that apply to your situation

- Most current complete bank/credit union statements; checking and savings accounts.
- Most current cash deposit (CD), stocks, bonds, or investment account statements.
- Financial Statement confirming your business equity
- Documentation confirming any miscellaneous assets listed



Financial assistance application

Sign, date and return with supporting financial documents. All information will be kept confidential.

Guarantor/ Responsible party information				
Last name:		First name / MI:		Relationship to patient:
U.S. Citizen/ Permanent Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Birth:	Social Security No:	Marital status:
Current address (city, ST & zip):				Home No:
Current employer name:				Work No:
Patient information (only complete if different from guarantor/ responsible party)				
Last name:		First name / MI:		Date of Birth:
U.S. Citizen/ Permanent Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No			Social Security No:	
Spouse/ significant other information				
Last name:		First name / MI:		Relationship to patient:
U.S. Citizen/ Permanent Resident: <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Birth:	Social Security No:	Marital status:
Current address (city, ST & zip):				Home No:
Current employer name:				Work No:
Does yours or your spouse's employer offer medical benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Household information				
Household size (including self):		Ages of children in household:		
Monthly income			Monthly expenses	
	Guarantor/ Resp. party	Spouse/ other	Rent/ mortgage:	\$
Gross income:	\$	\$	Health insurance:	\$
Unemployment benefits:	\$	\$	Hospital bills/ medication:	\$
Social Security/ Pension(s):	\$	\$	Auto insurance:	\$
Child support/ alimony:	\$	\$	Total credit card debt:	\$
Gov't assist/ food stamps:	\$	\$	Total mortgage balance:	\$
Other source(s) of income:	\$	\$	Other:	\$
Other source(s) of income:	\$	\$	Other:	\$
Other information				
Last year's household income:		Did you file taxes last year? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please state the reason why:	
Tax waiver: I/ we certify by my/ our signature I/ we did not have sufficient taxable income to file for last year.				
Signature:		Date:	Spouse/ other signature:	
Signature:		Date:	Spouse/ other signature:	
I hereby certify the information contained in the above financial questionnaire is accurate & complete to the best of my knowledge and authorize Tuality Healthcare to verify the information provided in this application & supporting documents.				Date:
Guarantor/ Responsible party's signature:				Date:
Spouse/ Significant other's signature:				Date:

