Applying for Financial Assistance

Inside you will find the application form to process your request for financial assistance for your account(s) with Columbia Memorial Hospital.

For financial assistance consideration, all of the following documents that are relevant to you must be signed and returned to the Business Office within 14 working days:

- Completed Financial Assistance Application Form (inside this brochure)
- Copies of your most recent Federal and State income tax returns
- Last two payroll stubs for all sources of income
- Last two months of bank statements
- Social Security benefit letter
- Oregon Health Plan (OHP) application denial letter

After receiving your complete application form and other documents, the hospital will consider and verify your application information. You will be notified of the decision within three weeks.

If you have any questions, please give us a call at **503-338-7530** or send us an email **FinancialCounselor@columbiamemorial.org**.

COLUMBIA MEMORIAL HOSPITAL

PLANETREE DESIGNATED

Columbia Memorial Hospital
Financial Counseling, Business Office
2111 Exchange St.
Astoria, OR 97103
Phone: 503-338-7530
Email: FinancialCounselor@columbiamemorial.org

For more information on services, visit www.columbiamemorial.org.

M-BR02 (REV6/2016) Q:Form

COLUMBIA MEMORIAL HOSPITAL'S

Application for Financial Assistance

COLUMBIA MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

Please answer the questions below as completely as possible. All information will be kept confidential. If you have any questions please call (503) 338-7530 or 1 (800) 962-2407 (WA/OR only). Monday-Friday 7:30 a.m. to 6 p.m.

Date Patient's Name Last First M.I. Social Security Number DOB

Patient's Account Number(s) Balance Health Insurance

Mailing Address Telephone How long

Spouse/Parent/Guardian Address Telephone

Names of Adults in Household currently employed SS# Employer Work# How Long

(1)_____

(2)_____

Total # in household _____

List Children in Household

First Name	Last Name	Age

	ADULT HOUSEHOLD INCOME	Person (1)	Person (2)
A	Amount in checking / savings account		
B	Monthly income, gross (attach verification)		
C	Unemployment benefits		
D	How long employed		
E	Social Security, pensions (attach verification)		
F	Alimony/child support (attach verification)		
G	Government assistance, food stamps (attach verification)		
H	Source and amount of other income (attach verification)		

Please check that you have provided: ☐ **Previous year's complete Federal tax return** ☐ **Bank statements for the last 2 months** ☐ **Income verification showing YTD earning or Pay Stubs for the last 2 months**

I hereby certify the information in the above financial questionnaire is correct and complete to the best of my knowledge. I authorized Columbia Memorial Hospital at their expense to run a credit and or asset report for verification. I agree that the hospital reserves the right to collect The Financial Assistance Award if at a later date a liability settlement, insurance coverage, state programs or government programs coverage becomes available.

Responsible person's signature_____ _____ Date_____

Please list what you feel you can pay each month

$_____

COLUMBIA MEMORIAL HOSPITAL
BUSINESS OFFICE – FINANCIAL ASSISTANCE APPLICATION