ASANTE®

At Asante, our mission to provide quality healthcare in a compassionate manner, valued by the communities we serve, involves much more than the treatment of illness or injury. At a time when their focus should be on healing, many people are concerned with the financial challenges of healthcare. The Asante Financial Assistance program offers financial support and guidance to our patients who may not have the means to pay for all of their medical expenses. By identifying affordable payment options and/or reduced fees, Asante's Financial Assistance program allows our patients to concentrate on what is most important - their health.

What does financial assistance cover? Asante's financial assistance covers hospital-based services provided by Asante Rogue Regional Medical Center, Asante Three Rivers Medical Center, and Asante Ashland Community Hospital depending upon your eligibility. Financial Assistance may not cover all health care costs, including services provided by other organizations. This assistance will cover Asante Physician Partners.

If you have questions or need help completing this application: Our financial assistance polices, information about the programs, and the application are available at https://www.asante.org/patients-visitors/bill-pay/financial-assistance/ or via phone 541-789-4111 option 2 (Toll Free 1-888-608-7632 option 2).

Federal and state law requires all hospitals to provide financial assistance to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income, even if you have health insurance. To view our financial assistance policy and sliding scale guidelines, please visit, https://www.asante.org/patients-visitors/bill-pay/financial-assistance.

In order for your application to be processed, you must:

- **Provide Asante with information about your family**
  Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- **Provide information about your family's gross monthly income (income before taxes and deductions) to include pay stubs, W-2 forms, tax returns, social security awards letters, etc.**
  (See financial assistance application Income Section for more examples)
- **Attach additional information if needed**
- **Sign and date the financial assistance application**

Note: **You do not have to provide a Social Security number to apply for financial assistance**. If you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

Mail completed application with all documentation to:
Asante Patient Financial Services, P.O. Box 4749 Medford, Oregon 97501.
Be sure to keep a copy for yourself, your documents will **NOT** be returned.
To submit your completed application: Fax 541-789-5522, email patient.credit@asante.org, or upload via your MyChart account.

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 21 days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly! You may receive bills until we receive your information.

Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION

Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*

Has the patient applied for Medicaid? □ **Yes** □ **No**

Does the patient receive state public services such as TANF, Basic Food, or WIC? □ **Yes** □ **No**

Is the patient currently homeless? □ **Yes** □ **No**

Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 21 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.

PATIENT AND APPLICANT INFORMATION

Patient first name	Patient middle name		Patient last name
□ Male □ Female □ Other (may specify _____)	Birth Date		Patient Social Security Number (optional)
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Social Security Number (optional)
Mailing Address _____ _____ City State Zip Code			Main contact number(s) ( ) _____ ( ) _____ Email Address: _____

Employment status of person responsible for paying bill

□ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed: _____)

□ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)

FAMILY INFORMATION

Household means: a single individual; or spouses, domestic partners, or a parent and child under 18 years of age, living together; and other individuals for whom a single individual, spouse, domestic partner, or parent is financially responsible.

FAMILY SIZE _____ *Attach additional page if needed*

Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support
- Work study programs (students) - Pension - Retirement account distributions - Other (*please explain_____)*

Charity Care/Financial Assistance Application Form – confidential

INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance.
All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.
Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

(This section is optional and may be used to determine eligibility for other assistance programs)

Monthly Household Expenses:

Rent/mortgage $_____ Medical expenses $_____
Insurance Premiums $_____ Utilities $_____
Other Debt/Expenses $_____ (*child support, loans, medications, other*)

ASSET INFORMATION

(This section is optional and may be used to determine eligibility for other assistance programs)

Current checking account balance
$_____
Current savings account balance
$_____

Does your family have these other assets?
Please check all that apply
□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s)
□ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

Refer to Consent for Financial Assistance Application document (attached)

ASANTE®

Consent for Financial Assistance Application

Date: _____
Patient: _____

Dear: _____

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P.O. Box 4749 Medford OR 97504

PATIENT AGREEMENT

I understand that Asante may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be denial of financial assistance, and I may be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying | Date

PATIENT LABEL