Evergreen
FAMILY MEDICINE
A Division of Centennial Medical Group

Application for discount on services rendered by Evergreen Primary & Urgent Care ONLY

Dear Patient:

Evergreen Family Medicine strives to provide high-quality, cost-effective, and compassionate medical care through a cohesive, primary care-based organization. Our obligations are to our patients, our community, our colleagues, our families, and ourselves. We strive to establish trust and mutual respect with our patients and to advocate our mutual interests within the healthcare system. Evergreen Family Medicine provides care without regard to ability to pay.

In light of this mission, we offer a variety of opportunities to assist with non-elective treatment, whether it be by absorbing part of the cost based on need or helping to identify community or governmental programs to fit your needs. This Sliding Fee Discount program is designed to provide discounted care to those who have no means, or limited means, to pay for their medical services (uninsured or underinsured). **This application is for a discount on services rendered by Evergreen Family Medicine Primary and Urgent Care and DOES NOT cover services rendered by Evergreen's Women's Health. To apply for a discount at Women's Health, it requires a different application.** If you wish to apply for financial assistance for your account, please complete the attached application and return it with any additional information required. **Financial assistance will only be applied to eligible accounts for services received 30 days prior to determinate date and any balances incurred within 12 months after the approved date. Your situation will be evaluated based on gross income and family size only, using the Census Bureau definitions of each.** We will gladly consider you for financial assistance provided that the application is completed, signed, and returned with the all required verification necessary.

Note: Patients who qualify to receive a discount will have a $20 nominal charge per visit. However, patients will not be denied services due to an inability to pay. The nominal fee is not a threshold for receiving care and thus, is not a minimum fee or co-payment.

Stewardship. Patient-care. Integrity. Respect. Innovation. Teamwork

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Official Use Only

DOS	Received Date

Financial Disclosure (Please Print Legibly)

Responsible Party: _____ Age: _____ Birth Date: _____ SS# _____

Spouse/ Partner: _____ Age: _____ Birth Date: _____ SS# _____

Mailing Address: _____ City _____ St _____ Zip _____ Phone _____

Marital Status: Single ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed ☐
(Provide copy)

Number in family _____

Dependents (as listed on your taxes)

Name	DOB	Relation	Name	DOB	Relation

Income and Financial Data

Status (employed/ unemployed Student/ disabled/retired) **Employer** Name Job Title **Hire Date** (mm/yy) **Pay Cycle** (ex. Weekly, monthly)

Print information on line below for each party only if applicable

Responsible Party: _____

Spouse/Partner: _____

Hourly Pay/ Monthly Gross Wages: ***Print information on line below for each party only if applicable***

Responsible Party: _____ Spouse: _____

If Unemployed: Previous Employer | How long Unemployed? | If you expect To return, when? | Unemployment Remaining | Monthly Compensation

Print information on line below for each party only if applicable

Responsible Party: _____

Spouse/Partner: _____

Other Sources of Household Income:

Social Security / Disability monthly amount: _____

Pension / IRA monthly amount: _____

TANF grant monthly amount: _____

Child Support monthly amount: _____

Scholarships/grants: _____

Other sources: _____Amount: _____

Total Monthly Income: _____

If no income, how are you meeting your basic living needs? (Basic living needs are things like food, shelter, and clothing.)

_____

_____

Do you currently file taxes? ☐Yes ☐No If not, please explain why _____

Have you filed bankruptcy? ☐Yes ☐No ☐Chapter 7 ☐ Chapter 13

Date filed: _____ Date discharged: _____

Checklist

Have you answered all the questions? Do not leave anything blank. Attach additional sheets if necessary.

Provide income verification (if applicable). **Accepted forms of verification:**

- **Most recent year's** US Individual 1040 tax return (all forms filed including W-2 and all schedules). If you need to obtain a copy, please call 1-800-908-9946 for a free transcript. **Please only submit tax forms if last year's taxes are representative of current year's income!**
- **Recent months'** worth of representative pay stubs
- Letter from employer stating number of hours worked per week, hourly pay, and pay cycle
- Social Security Benefit Letter **for current year**
- VA benefit letter **for current year**
- Unemployment benefit letter
- Child Support
- School account summary by term (for college students submitting scholarship/grant information)
- Detail of at least **three months** of recent income and expenses of business for **self-employed** individuals
- TANF Benefit Letter

****Additional information may be requested in order to qualify for assistance****

In order to serve you best, we require a month's worth of verification of **ALL income *(self-employed is three months income and expenses)***. Please refer to the checklist on the previous page to view a list of options of verification forms we will accept. If you have any questions throughout the application process, please feel free to ask. Applicants will have **two weeks** after submitting the financial aid application to provide any additional information that is required. If at the end of these two weeks all required verification has not been received, your application will be closed and a closure letter will be sent to you, the applicant. Thereafter, if you wish to re-open your application for financial assistance a new application will need to be completed.

Patients approved for financial assistance will be granted eligibility for services received **by Evergreen Urgent Care and Primary Care offices for 30 days prior to determinate date and any balances incurred within 12 months after the approved date.**

**Any accounts turned over for collection as a result of the patient's delay in providing information will not be considered for the Sliding Fee Discount Program. **

Please Read the Following Before Signing and Dating the Application

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize the Department of Human Services, any bank, insurance company, real estate firm, financial institution and credit grantors of any kind to disclose, to any authorized agent of Evergreen Family Medicine, information as to my past and present accounts, policies, experiences and all pertinent information related thereto.

Signature (Applicant or Guarantor)	Date
Signature (Spouse/Partner)	Date

At least one signature is required

Return Completed Application and Documents to:

Evergreen Family Medicine
2570 NW Edenbower Blvd
Roseburg, OR. 97471
Phone: (541) 677-7200 ext. 318