Central Oregon Pediatric Associates
2200 NE Professional Ct
Bend, Oregon 97701
P (541) 389-6313 **F** (541) 322-0064

Hardship Application Form

Central Oregon Pediatric Associates is committed to offering financial assistance to families who have healthcare needs and are not able to pay for care. Patients must use all other resources, such as application to The Children's Health Insurance Program, before financial assistance will be considered. Eligibility for assistance is based upon total gross income (how much you make before taxes), and the number of dependents in the family. People who have unusual situations may receive further consideration.

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

- ❑ **Provide us 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 us information about your family's gross monthly income (income before taxes and deductions)**
- ❑ **Provide documentation for family income and expenses**
- ❑ **Attach additional information if needed**
- ❑ **Sign and date the form**

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 or drop off the completed application with all documentation to: COPA, 2200 NE Professional Ct, Bend, Oregon 97701.
**Be sure to keep a copy for yourself.*

We will notify you of the final determination after 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 will continue to receive bills until we receive your information.

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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 ** May be required to apply before being considered for financial assistance*

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.
- Information on your application may be verified and we may ask for additional information or proof of income.

APPLICANT INFORMATION

Legal Last Name(s)	**Legal First Name**	**Legal Middle Name**	❑ Male ❑ Female ❑ Other

Date of Birth: | Social Security #: ______ - _______ - _______ | Email:

Mailing Address:	**Main contact numbers**	**Employment Status**
Street:	Cell: (_____) ______ - _________	❑ Employed - Date of Hire:________
	Home: (_____) ______ - _________	❑ Self-Employed ❑ Retired
	May we leave a detailed voicemail?	❑ Student ❑ Disabled
	❑ Yes	❑ Other:_________________
City State Zip Code	❑ No	❑ Unemployed (how long:_______)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes patient, responsible party, spouse, natural or adopted children under age 18, and live-in partner if together you have natural or adopted children under age 18.

FAMILY SIZE _________ **Attach additional page if needed*

Name (Last, First)	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):	Applying for financial assistance?	Medical insurance provider
					❑ Yes / ❑ No	
					❑ Yes / ❑ No	
					❑ 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_____________)

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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.

EXPENSE INFORMATION

We use this information to get a more complete picture of your financial situation.

Monthly Household Expenses:

- Rent/Mortgage $__________________
- Medical Expenses $__________________
- Insurance Premiums $__________________
- Utilities $__________________
- Other Debt/Expenses $__________________ (Child Support, loans, medical/medication, other etc

ADDITIONAL INFORMATION

Please include any additional information or extenuating circumstances below:

PATIENT AGREEMENT

❑ 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 Applicant	Printed Name	Date