THE OREGON CLINIC

PO Box 5277
Portland OR 97208
(503) 963-2900

In order to be considered for charity, please complete the following in it's entirety (front and back). Please attach copies of previous year's tax return and current income verification for the last 3 months (pay stubs, Social Security income statement, unemployment benefit statement). Return to our office in the enclosed envelope within 7 days. If you have any questions or need help in completing the application, please contact the Financial Counselor.

Account:	Financial Counselor:	Phone: (503) 963-2900	Date:

General Information

Patient Name _____ Social Security_____/____/_____DOB_____/_____/_____
Last First Middle

Address _____
Street City State Zip

Home Phone (_____)_____ Work (_____)_____ Years at address _____

Marital Status ❑Married ❑Single ❑Divorced ❑Separated ❑Widowed

Responsible Party_____ Social Security_____/____/_____ Relation_____
(If different from patient, or spouse information)

Address _____
Street City State Zip

Number of people in household: _____ Names and ages:_____

Health Insurance Carrier: _____ Effective Date _____/_____/_____

Household Income

	Person 1	Person 2	Person 3
How many people employed? _____ Name	_____	_____	_____
Relation	_____	_____	_____
Employer Name	_____	_____	_____
Phone	(____)_____	(____)_____	(____)_____
Length of time	_____Yrs_____Mos	_____Yrs_____Mos	_____Yrs _____Mos
Monthly Gross (attach verification)	$_____	$_____	$_____
Retirement/Pension	$_____	$_____	$_____
Alimony/Child Support	$_____	$_____	$_____
Government Assistance/Food Stamps	$_____	$_____	$_____
Other Sources of Income (Please Explain)	$_____	$_____	$_____
TOTAL	**$**_____	**$**_____	**$**_____
Checking Account Balance(s)	$_____	$_____	$_____
Savings Account Balance(s)	$_____	$_____	$_____
Stocks/Bonds/IRA's/Investments	$_____	$_____	$_____
Residence Value (if own/buying)	$_____	$_____	$_____
Vehicle value (auto, RV, off road)	$_____	$_____	$_____
Make and year	_____	_____	_____

Monthly Expenses/Bills

Please list all doctor, hospital and medical bills not covered by your insurance:

Name of Provider	Monthly Payment Amount	Balance
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
_____	$_____	$_____
Medications	$_____	
Health Insurance Premiums/Copays/Coinsurance	$_____	
Household Expenses		
Rent/Mortgage	$_____	
Taxes	$_____	
Vehicle 1	$_____	
Vehicle 2	$_____	
Vehicle 3	$_____	
Insurance	$_____	
Utilities	$_____	
Food	$_____	
Living (Gas, Clothes, etc.)	$_____	
Child Care, Support/Alimony	$_____	
Credit Cards (total)	$_____	$_____
Entertainment	$_____	
Other (Please Explain) _____	$_____	
TOTAL	**$**_____	

COMMENTS of situation/circumstances (Use additional/separate page if needed)_____

_____

_____

I, _____ hereby certify that the information contained in the above financial statement is correct and complete to the best of my knowledge. I am requesting consideration for a charity adjustment on my outstanding debt with The Oregon Clinic due to financial hardship. I further understand that misrepresentation or falsification of any information will disqualify my application from consideration.

Patient/Responsible Signature_____Date_____/_____/_____