Financial Assistance
Application Form Instructions

This is an application for financial assistance at Springfield Family Physicians.

Springfield Family Physicians provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free or reduced-price care based on your family size and income, even if you have health insurance.

What does financial assistance cover? Financial assistance covers appropriate primary care based on services provided by Springfield Family Physicians depending upon your eligibility.

If you have questions or need help completing this application: Please contact our Business Office in person or call us at 541-747-4300. You may obtain help for any reason.

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). Include income proof in form of pay stubs or tax return documents.
- Attach additional information if needed
- Sign and date the form

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 fax completed application with all documentation to: Springfield Family Physicians Attn: Business Office 2644 Suzanne Way Eugene OR 97408. Fax: 541-747-0655. Be sure to keep a copy for yourself.

To submit your completed application in person: You can drop off your completed application to any of Springfield Family Physicians Clinics. Hours of operation are 8 am to 5 pm.

We will notify you of the final determination of eligibility within 14 calendar days of receiving a complete financial assistance application, including documentation of income.

SPRINGFIELD
FAMILY PHYSICIANS

Springfield Family Physicians 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

Does the patient need an interpreter? ❑ **Yes** ❑ **No** *If Yes, list preferred language:*

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

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

Is the patient currently experiencing homelessness? ❑ **Yes** ❑ **No**

Is the patient's need for medical care 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.*
- *Within 14 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance.*

E PATIENT AND APPLICANT INFORMATION

Patient First Name	Patient Middle Name		Patient Last Name
❑ Male ❑ Female ❑ Other *May Specify:*	Birth Date		Social Security Number (Optional)
Person Responsible For Paying Bill	Relationship	Birth Date	Social Security Number (Optional)
Mailing Address			Main Contact Number(s)
City	State	Zip Code	Email Address:

Employment status of person responsible for paying bill

❑ **Employed** *Date of hire:* _____ ❑ **Unemployed** *How long unemployed:* _____

❑ **Self-Employed** ❑ **Student** ❑ **Disabled** ❑ **Retired** ❑ **Other:**

SPRINGFIELD FAMILY PHYSICIANS

FAMILY INFORMATION

List family members in your household, including you. “Family” includes people related by birth, marriage, or adoption who live together. **FAMILY SIZE** _____

INCOME INFORMATION

You must provide information on your family’s income and proof of income. **GROSS MONTHLY INCOME: $_____**

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ADDITIONAL INFORMATION

Please use this section if you have 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.

SPRINGFIELD
FAMILY PHYSICIANS

PATIENT AGREEMENT

I understand that Springfield Family Physicians 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 information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Person Applying Date