

FINANCIAL ASSISTANCE APPLICATION

Please answer the questions below as completely as possible. All information will be kept confidential. If you have any questions, please call 541.274.6699, Monday through Friday, 8:00 AM to 4:30 PM.

Date	Patient's Name	Last	First	M.I.
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Address	Date of Birth	Telephone Number
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Patient's Account or Guarantor Number _____

Person responsible for paying the bill and relationship to patient	Date of Birth	Telephone Number
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Are you eligible for presumptive financial assistance due to any of the following conditions:

- Homelessness or housing instability
- Incarceration
- Enrollment in any of the following programs: Medicaid, Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), low-income home energy assistance programs, or any other similar program.

Please provide the monthly income for each non-dependent adult in the household. Be sure to include wages, salary, commissions, tips, self-employment income from non-farm or farm businesses, railroad retirement, VA benefits, pensions, rental income, annuities, unemployment wages and supplemental security income (SSI).

All household members including patient	Date of Birth	Monthly Income/Type
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Total number of people in household: _____ Total household income: _____

Please provide the following supporting documentation for the income amounts stated above, and for proof of 0 income for any non-working, non-dependent adults in the household:

- Income verification for the past 3 months for each person with income
- Most recent tax returns (if legally required to file)

Additional Information: _____

Financial Counseling Office Use Only

Date Rec'd _____ Verified _____

Approved

Denied

Comments: _____

Expiration Date: _____

The above application is true to the best of my knowledge. If the hospital seeks verification of the information, I authorize any party contacted by the hospital to release the requested verification to the hospital.

Date: _____ Applicants Signature: _____

If you have any questions, please contact our Financial Counselors at 541-274-6699. Our office is open 8am-430pm – Mon-Fri.

How to Apply for Financial Assistance at Sky Lakes Medical Center

Step 1: Understanding Your Eligibility

At Sky Lakes Medical Center, we provide financial assistance for non-elective, medically necessary services based on the Federal Poverty Income Guidelines. Our goal is to ensure that financial difficulties do not prevent you from receiving essential medical care. All patients, regardless of insurance status, are welcome to apply.

Financial assistance applies only to accounts billed by Sky Lakes. Other independent physicians, including some surgeons, pathologists and other specialists may bill separately. Hospital financial assistance would not be applied to those bills. Additionally, financial assistance cannot be applied to any ambulance, air flight or other transportation services.

Step 2: Start Your Application

You have **240 days** from the date of your first billing statement (for the date of service) or **12 months** after making a payment for services to apply for financial assistance. This ensures you have ample time to gather necessary documents and complete your application.

Step 3: Collect Required Documents

To apply, you may need to provide three months of income verification, federal income tax records for the most recent filing year and/or additional supporting documentation to determine household size and income, if needed.

Step 4: Determination Process

Once you submit your application, we will review it based on the provided documentation. If more information is needed, you will receive a letter explaining what is required. You will get a determination within 10 days of completing your application. Determinations are based solely on your household size and household income. No assets will be considered.

Step 5: Appeals Process

If your application is denied or deemed incomplete, you can appeal the decision. We will provide clear instructions on how to correct deficiencies or submit an appeal. During the appeal process, all collection activities will be suspended.

Thank you for trusting Sky Lakes Medical Center with your healthcare needs.

skylakes.org/patients-visitors/billing-and-insurance/financial-assistance/