Financial Assistance Application Form Instructions

This is an application for financial assistance for BestMed Health Clinics.

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

What does financial assistance cover? The financial assistance program may cover outstanding balances on services that are deemed as medically necessary. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: Please contact Customer Service at

541- 228-3865.

In order for your application to be processed, you must provide us information about your family members in your household as well as provide us information about your family's gross monthly income (income before taxes and deductions). Please attach additional information if necessary. You are also required to sign and date the form.

Mail completed application with all documentation to:

BestMed

PO BOX 4858

Portland, OR 97208

We will notify you of the final determination of eligibility, if applicable, within 30 calendar days of receiving a complete financial assistance application, including documentation of income. You will continue to receive statements and your account will continue to age, until you have been approved for financial assistance.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Request for Financial Assistance Form

Patient Information **Account # _____**

First Name_____ Last Name_____ MI___ Date of Birth_____

Street Address_____City_____State_____Zip_____

Email Address_____ Phone_____

Guarantor Information

First/Last Name_____Relationship_____

Street Address_____City_____State_____Zip_____

Household Information: Please indicate all people living in your household, including the applicant.

Income includes (pre-tax) wages, child support, rental income, unemployment income, social security benefits, alimony, public assistance etc.

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER NAME	MONTHLY GROSS INCOME

Financial Information

Are you a full time student? ☐ Yes ☐ No *If yes, please send student loan report.*

Do you receive any form of public assistance (food stamps, HUD housing, etc.)? ☐ Yes ☐ No
If yes, please send proof.

Monthly costs of medications or medical supplies_____

Authorization

I hereby agree that the information in the above financial assistance form is correct and complete to the best of my knowledge. I understand that proof of income and/or a credit report may be necessary. I authorize BestMed Healthcare to verify any and all information above and understand that a credit report may be necessary to determine approval.

Patient or Guarantor Signature_____Date_____