

Compassionate Care Program Application

- Granting of financial assistance is contingent upon meeting eligibility guidelines.
- You will be notified by an NUNM staff member regarding your application status.
- You must provide proof of income with this application.

1. **Patient:** _____
First Name Last Name Date of Birth

2. **What county do you currently reside in?** _____ **Zip Code?** _____

3. **Do you currently have medical insurance of any kind?** Yes No
 If yes, please list name/type of insurance if applicable _____

4. **NUNM offers enrollment assistance for Medicaid/Oregon Health Plan. Would you be interested in being connected with an enrollment assistor?** Yes No

5. **What is your Household size and combined gross household income:**

Combined, Gross Household Income			
# of people in household	Gross Income	Frequency (Circle one)	Employer/Source
	\$	Weekly Bi-Weekly Monthly Yearly	

Household Members:	Name(s):	Date of Birth:
Self:		
Spouse:		
Other:		
Other:		
Other:		
Other:		

I certify this information to be a true and accurate account of my household and financial status at this time. I have read and agree to the financial assistance application provisions.

Applicant Signature: _____ Date: _____

This section to be filled out by administrative personnel only: MRN: _____

1. Financial Assistance: Tier 1 / Tier 2 / Tier 3 / Tier 4 (circle one)
2. Coverage added to EPIC account Yes / No Date coverage added: _____
3. Proof of Income provided: W2 / Paystub / Other: _____/Pending
4. Staff Member Name: _____