Date Completed: _____

MRN: _____

DOB: _____

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

COMPASSIONATE CARE APPLICATION

Proof of income is required for completion. Requirements must be met in full for enrollment in our financial assistance program. You will be notified by an NUNM staff member regarding your application status.

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:
   _____
4. **NUNM offers enrollment assistance for Oregon Health Plan (OHP)/ Oregon Medicaid.**
   Would you like an application assister to contact you to set up an enrollment appointment? ☐ Yes ☐ No

   Phone:_____

   Email:_____
5. **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:
Yourself:		
Partner:		
Other:		
Other:		
Other:		
Other:		

6. **Please check all that apply to you.**

☐ Federal Retiree or Federal Medicare Recipient ☐ Veteran ☐ 62 Years of Age of Older

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. If indicated I consent to having an NUNM representative contact me for OHP enrollment.

_____ _____
Printed Name of Applicant **Date**

_____ _____
Signature of Applicant **Date**

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SELF-DECLARATION OF INCOME

Complete the information below only if you have no other way to document your income. All of the boxes below must be checked and all questions answered. Failure to complete this form may result in denial of your application.

1. My current employer(s): _____

2. What is / are the source(s) of your income: _____

☐ I get paid in cash ☐ I do not get checks ☐ I do not get paystubs ☐ I do not file taxes

☐ I do not have a source of income

☐ I cannot get a letter from my employer - Please explain:

_____

_____

*My cash income is: $_____

*How often? (Weekly, Biweekly, Monthly, Yearly): _____

Applicants/recipients must read the following and sign below:

I certify that I have no other way to document my income and that all of the above information is true and correct. I understand that this information is to be used to determine eligibility for Public Health Insurance Programs. I understand that program officials may verify information on this form. I also understand that if I intentionally misrepresent my income, I may have to repay benefits received and may be prosecuted under State law.

_____ _____
Printed Name of Applicant Date

_____ _____
Signature of Applicant Date