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 within one month of filling out this application.**

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1. **Patient:** ______________________ ___________________________ ____________ ______________________
   First Name   Last Name   Date of Birth   Phone Number

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: ____

Revision date: 7/8/16 RCW