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

COMPASSIONATE CARE APPLICATION

This document and any eligible discounts will expire one year after application date. Please reapply yearly.

Proof of income is required. Requirements must be met in full for enrollment in our financial assistance program.

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

2. **(For Oregon Residents) NUNM offers enrollment assistance for the Oregon Health Plan (OHP)/ Oregon Medicaid.**

   Would you like an application assister to contact you to set up an enrollment appointment? ☐ Yes ☐ No

3. **Relationship to the Federal Poverty Level:**

   *Household Income is the combined gross (pre-taxed) income of all the members of a tax household (all legally connected or related people sharing a household or residence) who are 15 years of age and older.

Total # of People in Household	Combined Gross Income of Everyone in Household	How Often Does the Household Receive this Amount? (Circle One)
	$	Weekly Bi-Weekly Monthly Yearly

4. **Documents To Support Income Claim**

   What type(s) of document(s) did you bring to prove your household income? _____

   ☐ I have forgotten my documents and acknowledge that I will be given a courtesy period of 30 days to provide my documents. After that time I will not be eligible for discounts until I provide documentation.

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

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

6. **Discount Policy Acknowledgement**

   I understand that if I am eligible for a discount that it will be applied only at check-out.
   Discounts are not applied for individuals who request courtesy billing (to have a bill sent to their mailing address), or for patients who forget to pay after their appointment.
   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.

_____ _____
Signature of Applicant **Date**

STAFF USE ONLY: Circle the best discount option: Tier 1, Tier 2, Tier 3 / Time of Service Only / Honored Citizen
FPL %_____ / **Initial when complete**: FPL Field _____ / Patient Tier Flag _____ / Scanned documents _____

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INCOME VERIFICATION FORM

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

☐ I currently am unemployed and have no source of income.

☐ I do not have easy access to my paycheck stubs or income statements.

☐ I am self-employed with various sources of income.

☐ I do not file taxes and do not have a tax return statement.

☐ I do work that pays in cash only.
What is / are the source(s) of your income: _____

☐ I have a different reason- Please explain: _____
_____
_____
_____

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 and is reassessed on an annual basis. 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.

_____ _____
Signature of Applicant Date

STAFF USE ONLY: Circle the best discount option: Tier 1, Tier 2, Tier 3 / Time of Service Only / Honored Citizen
FPL %_____ / Initial when complete: FPL Field _____ / Patient Tier Flag _____ / Scanned documents _____