MCMC
MID-COLUMBIA MEDICAL CENTER
A Designated Planetree Patient-Centered Hospital

Dear Patient and Family:

Mid-Columbia Medical Center's (MCMC) Philosophy is to humanize, personalize, and demystify the healthcare experience for patients and their families. Our Values are high quality, cost-effective healthcare services for every patient regardless of their ability to pay. In keeping with this Philosophy, we recognize that medical bills for medically necessary services are often unexpected and, at times, difficult to pay. MCMC's Financial Assistance program offers financial support and guidance to support our mission of providing outstanding patient care to the Mid-Columbia region.

If you are unable to pay for your medically-necessary services, due to limited financial resources, you may qualify for our Financial Assistance program. This is a hospital-based program which may reduce the amount you owe.

Application Process To apply for financial assistance, complete and return this form to:

Mid-Columbia Medical Center Patient Accounts 1700 E. 19th The Dalles, OR 97058

The following information is required to process your application:

- Copies to support any income listed on the application
- Copies to support any bills listed as expenses
- Additional information may be required to process your application

Questions? Please call our Self Pay Account Representatives at 541-296-7500 Monday – Friday 7:30 a.m. to 5:00 p.m.

This completed application and supporting documentation must be received in our office by the 20th of the month to be processed in the current month. Applications received after the 20th will be processed the following month.

To review Mid-Columbia Medical Center's Financial Assistance Policy, please visit our web site at www.mcmc.net

Sincerely,

Mid-Columbia Medical Center

MID COLUMBIA MEDICAL CENTER
Financial Assistance Application

541-296-7500 or 541-296-7404

Patient Name: _____

Account Number: _____

INCOME AND ASSETS

EXPENSES AND LIABILITIES

INCOME: (use yearly gross totals)	Yours	Spouse or Other	OTHER EXPENSES:	Monthly Payment	Balance
Wages:			Mortgage/Rent:		
Social Security Benefits:			Real Estate Loans:		
Unemployment Benefits:			Car Payments A):		
Public Assistance:			B):		
Child Support:			Food:		
Other:			Utilities/Heat:		
Interest Income:			Bank/Credit Cards:		
Total Income:					
ASSETS:			Other Credit:		
Savings, IRA's:			Medical Expenses:		
Stocks, Bonds, Cash:					
Value LIfe Insurance:					
Primary Home Value:					
Other Property Value:			**INSURANCE:**		
Primary Auto Value/Year:			Auto:		
Second Auto Value/Year:			Medical:		
Attach copy of most recent bank statement			Life:		
			Other:		
Total Assets:			**Total Expenses:**		

Number in Household _____

Proposed Monthly MCMC Payment: $

Requested Payment Date:

I certify that the above information is true and correct to the best of my knowledge. All information is subject to verification and I will provide the requested documentation.

Signed: Date:

Signed: Date:

FOR OFFICE USE ONLY:

Approved Assistance: _____ No _____ Yes _____ Full _____ Partial % _____ Over Income: _____ No _____ Yes

Payment Arrangements: $ _____ per month. Write-off Amount: $ _____

Received By: _____ Date: _____ Approval By: _____ Date: _____

PLEASE DON'T FORGET TO ENCLOSE THE REQUESTED PHOTOCOPIES. YOUR APPLICATION CAN NOT BE PROCESSED WITHOUT THEM.

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