Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

Financial Assistance Application

As caring health care providers, we understand medical bills may be difficult to pay. Patients who do not have health insurance and who are unable to pay for all or part of their health care services, may apply for financial assistance. The Financial Assistance Program at Northwest Gastroenterology Clinic, LLC and NGC Endoscopy Services, LLC provides free or reduced care based upon a patient's ability to pay.

APPLICATION PROCESS: To apply for financial assistance, complete and return this form to:
Northwest Gastroenterology Clinic
1130 NW 22nd Ave Ste 410
Portland, OR 97210

The following information must be included with the application:

- Most recent federal tax returns-Form 1040 and, if self-employed, add schedule C documentation
- Copies of the most recent income information for each person in the household including pay stubs, Social Security, unemployment, retirement, pensions, etc.
- If the household is receiving financial support from family or friends, provide a letter detailing the support from the assisting party.

Without the above listed items, we will be **unable** to process the application.

This completed application, including the supporting information, should be returned within ***14 days*** of the receipt.

By submitting the application for assistance, patients give NW Gastroenterology Clinic, LLC and NGC Endoscopy Services, LLC consent to make necessary inquiries to confirm financial obligations or references.

If you have any questions or concerns please contact the billing staff at (503) 229-7461.
Thank you.

Northwest Gastroenterology
CLINIC & ENDOSCOPY CENTER

FINANCIAL ASSISTANCE APPLICATION

PATIENT INFORMATION

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER

ADDRESS STREET	CITY	STATE ZIP	TELEPHONE

DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)	U.S CITIZEN YES NO

RESPONSIBLE PERSON'S NAME (GUARANTOR)	DATE OF BIRTH	TELEPHONE

HOUSEHOLD INFORMATION (PLEASE INCLUDE YOURSELF)

Please list anyone living in your household (including yourself), Income includes (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, public/government assistance, rent or living expenses exchanged for services provided, etc.

HOUSEHOLD MEMBERS	AGE	RELATION	SOURCE OF INCOME	MONTHLY GROSS INCOME	INSURED?
1		SELF			
2					
3					
4					
5					
6					

EXPENSES AND ASSETTS

RENT $_____

MORTGAGE PMT $_____ SEND PROOF

MORTGAGE BALANCE $_____ SEND PROOF

COST OF UTILITIES $_____

CHECKING ACCOUNT BALANCE $_____

SAVINGS ACCOUNT BALANCE $_____

MONTHLY CHILD CARE $_____

CAR PAYMENT $_____

YEAR AND MAKE OF VEHICLE_____

RECREATIONAL VEHICLES_____

HEALTH INSURANCE PREMIUMS $_____

STOCKS, BONDS, RETIREMENT ACCOUNTS ETC. _____

REAL ESTATE OTHER THAN PRIMARY HOME _____

OTHER ASSETS_____

ARE YOU A FULL TIME STUDENT? _____ PLEASE SEND STUDENT LOAN REPORT

DO YOU RECEIVE ANY FORM OF PUBLIC ASSISTANCE?_____ IF YES, PLEASE SEND PROOF

MONTHLY COSTS OF MEDICATIONS OR SUPPLIES $_____

ARE YOU BEING SUPPORTED BY A PARENT OR OTHER PERSON? _____

MONTHLY CHILD CARE $_____

IF YOU NEED TO WRITE A LETTER EXPLAINING YOUR INDIVIDUAL SITUATION PLEASE ATTACH IT TO THIS FORM

DOCUMENTATION

PLEASE CHECK THAT YOU HAVE INCLUDED ONE THE FOLLOWING:

☐ COPY OF PREVIOUS YEAR'S TAX RETURNS

☐ COPY OF LATEST BANK STATEMENT

☐ INCOME VERIFICATION OR PAY STUBS

AUTHORIZATION

I HEREBY CERTIFY THE INFORMATION CONTAINED IN THE ABOVE FINANCIAL QUESTIONNAIRE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AUTHORIZE NW GASTROENTEROLOGY CLINIC, LLC AND NGC ENDOSCOPY SERVICES, LLC TO VERIFY ANY OR ALL INFORMATION GIVEN.

RESPONIBLE PERSON'S SIGNATURE_____ DATE: _____