



TCC Revenue Cycle Manager will review this application to determine your options for payment of medical services. The information contained herein is protected by The Children's Clinic confidentiality policy and will only be used to establish payment plans and /or hardship adjustments.

Guarantors: Please submit your completed application AND all required documentation to TCC Billing Office within 14 days.

The following items must be included for consideration:

- **Copy of most recent tax return**
- **Copy of most recent bank statement for ALL bank accounts.**
- **Copy of last 2 paystubs or last 2 unemployment paystubs for the patient's household and both parents if employed.**

If your application is incomplete, it will be denied, and recovery efforts will resume. Applications will be reconsidered upon receipt of the remaining information.

Please allow 14 business days to process your application. If you do not receive a response or require assistance completing this application, please contact our billing team at (503) 535-1458.

RETURN COMPLETED APPLICATIONS TO:

**The Children's Clinic
Attn: Billing Office
9450 SW Barnes Road #200
Portland, OR 97225**

In order for The Children's Clinic to provide fair and legal payment options for all patients, we use the national Poverty Guidelines published by the U.S. Department of Health and Human Services. We offer hardship adjustments on a sliding scale based on these guidelines and the supporting documentation provided with your application.

STATEMENT OF FINANCIAL RESOURCES

Today's Date: _____

Account #: _____

Guarantor Name: _____

SECTION 1- FAMILY INFORMATION

Number of people in household: _____

Age of Head of Household: _____

List all household members:

NAME	RELATIONSHIP	DATE OF BIRTH	AGE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

For additional members, please list on back of page.

SECTION-2 EMPLOYMENT/OTHER INCOME

Household Income:

Name (s): _____ Relationship to patient: _____

GROSS INCOME for these months:

Month/Year: _____ \$ _____ Month/Year: _____ \$ _____

Month/Year: _____ \$ _____ Month/Year: _____ \$ _____

Current Employer: _____ Occupation: _____

Other sources of Income: _____

SECTION-3 EXPENSES

MONTHLY AMOUNTS

Rent/Mortgage:_____

Utilities:_____

Medical Expenses:_____

Vehicle (s):_____

Groceries:_____

SECTION-4 COMMENTS YOU WISH TO MAKE

I certify the above information is true and accurate to the best of knowledge. I agree to notify TCC if my circumstances change, for example, if I obtain new insurance coverage or change employment, Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc) which may be available for payment of my clinic/provider charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the clinic/provider the amount recovered for clinic/provider charges. If any information I have given proves to be untrue, I understand that the clinic/provider may re-evaluate my financial status and take whatever action becomes appropriate.

NOTE: A DEPOSIT MAY BE REQUIRED FOR SERVICES RECEIVED PRIOR TO FINANCIAL ASSISTANCE DETERMINATION.

Applicant's Signature:_____

Date:_____