

## Financial Assistance Application

**This is an application for financial assistance (also known as charity care) at ZoomCare .**

ZoomCare provides financial assistance in accordance with state and federal requirements to people and families who meet certain income requirements. You may qualify for free care or reduced-price care based on your family size and income. Even if you have health insurance. To view ZoomCare's Financial Assistance Policy and additional information, please visit [ZoomCare.com](https://www.zoomcare.com) .

### **What does financial assistance cover?**

ZoomCare financial assistance covers appropriate provider-based services provided by ZoomCare depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

### **If you have questions or need help completing this application:**

Please contact the Patient Support Center at 844-966-6777. You may obtain help for any reason, including disability and language assistance.

### **In order for your application to be processed, you must:**

- Provide us information about your family: Fill in the number of family members in your household (family includes people related by birth, marriage, or adoption who live together)
- Provide us information about your family's gross monthly income (income before taxes and deductions)
- Provide documentation for family income
- Attach additional information if needed
- Sign and date the form

### **Note: You do not have to provide a Social Security number to apply for financial assistance.**

If you provide us with your Social Security number, it will help speed up processing of your application. Social Security numbers are used to verify the information provided to us. If you do not have a Social Security number, please mark "not applicable" or "NA."

### **Patient Portal, Mail, or email completed application with all documentation to:**

By Online [Zoomcare.com](https://www.zoomcare.com), mail to: ZoomCare Patient Support Center, 11958 SW Garden Place, Tigard, OR 97223, or email: [billing@zoomcare.com](mailto:billing@zoomcare.com). Be sure to keep a copy for yourself.

**To submit your completed application in person:** Please contact the Patient Support Center for the closest drop-off location at 844-966-6777. We will notify you of the final determination of eligibility and appeal rights, if applicable, within 14 calendar days of receiving a complete financial assistance application, including documentation of income. By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

**We want to help. Please submit your application promptly! You may receive bills until we receive your information.**



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**All adult family members' income must be disclosed and proof included with completed application. Examples of income sources include:** Wages ■ Unemployment ■ Self-employment ■ Workers Compensation ■ Disability ■ SSI ■ Child/spousal support ■ Work study programs (students) ■ Pension ■ Retirement account distributions ■ Other  
*Please explain:*

### ADDITIONAL INFORMATION

Please use additional pages if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

### PATIENT AGREEMENT

- I understand that ZoomCare may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.
- I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.
- By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

Signature of Person Applying \_\_\_\_\_ Date \_\_\_\_\_

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[billing@zoomcare.com](mailto:billing@zoomcare.com) or 11958 SW Garden Place, Tigard, OR 97223**