Metropolitan Pediatrics

Financial Assistance Application

Billing & Financial Services will review this application to determine your options for payment of medical services. The information contained herein is protected by Metropolitan Pediatrics' 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 Billing & Financial Services within 14 days.

The following items must be included for consideration:

- ☐ **Copy of last year's tax return**
  If you did not file taxes, you must submit a letter from the IRS stating that you did not file a return. To obtain a letter, contact the IRS at 1-800-829-1040.
- ☐ **Three most recent pay stubs, including spouse (if applicable)**

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) 466-1668.

RETURN COMPLETED APPLICATIONS TO:

Metropolitan Pediatrics
Attn: Billing
200 SW Market Street, Suite 1650
Portland, OR 97201

In order for Metropolitan Pediatrics 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.

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GUARANTOR INFORMATION			
Name:	**Phone Number:**		
Address:	**City:**	**State:**	**Zip:**
Years at Current Address:	**Social Security #:** - -		
Employer:	**Employer Phone:**		
Employer Address:	**City:**	**State:**	**Zip:**
Years at Current Job:	**SUPERVISOR CONTACT INFO.**		
Average # of Hours/Week:	**Name:**		
Hourly Wages:	**Phone Number:**		

SPOUSE INFORMATION			
Name:	**Phone Number:**		
Address:	**City:**	**State:**	**Zip:**
Years at Current Address:	**Social Security #:** - -		
Employer:	**Employer Phone:**		
Employer Address:	**City:**	**State:**	**Zip:**
Years at Current Job:	**SUPERVISOR CONTACT INFO.**		
Average # of Hours/Week:	**Name:**		
Hourly Wages:	**Phone Number:**		

DEPENDENT INFORMATION

Using legal names, please list everyone (including yourself) who resides in your household.

Name	Relationship to You	Age

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INCOME		
Salary (Gross):	**Spouse - Salary (Gross):**	
Salary (Net):	**Spouse - Salary (Net):**	
Child Support:	**Alimony:**	**Rental Income:**
Social Security:	**Military Allotment/Veterans Benefits:**	
Unemployment:	**Family/Rental Assistance:**	
Workers' Compensation:	**Public Assistance:**	
Interest & Investment Income:	**Retirement/Pension:**	
Other:		

EXPENSES (monthly averages)			
RESIDENCE: Do you… ☐ **Rent?** – Amount:		☐ **Own?** – Mortgage Amount:	
Name of Landlord or Mortgage Company:			
Food:	**Phone:**	**Water/Sewer:**	**Utilities:**
Auto Maintenance:	**Insurance:**	**Other Insurance:**	
Child Care:	**# of Children in Child Care:**	**Name of Child Care:**	

OTHER PAYMENT OBLIGATIONS			
Creditor Name	**Description**	**Current Balance**	**Payment Amount**

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MEDICAL EXPENSES

In the next 3 months, what medical expenses are you anticipating, either from Metropolitan Pediatrics or any other healthcare provider?

_____
_____
_____
_____
_____
_____
_____

CONCLUSION/PATIENT STATEMENT

Additional details you feel are important:

_____
_____
_____
_____
_____
_____
_____
_____

LENGTH OF TIME REQUESTED TO PAY OFF MEDICAL SERVICES

The information provided within this application is true and complete to the best of my knowledge. I give permission to Metropolitan Pediatrics to verify any or all of the information listed above.

Signature | **Date**