



Sliding Scale Financial Assistance Application

Please fill out all information completely. Incomplete applications will result in a delay in the eligibility determination process. Information submitted as part of this application may be verified by BestCare staff. Applicants will receive an eligibility notification within 14 calendar days of submitting a completed application.

BestCare cannot guarantee that applicants will qualify for financial assistance. Not all services are eligible for financial assistance. Return to any BestCare location, mail to BestCare Billing Department, PO Box 1710 Redmond, OR 97756, or fax to 541-316-7422.

APPLICANT INFORMATION			
Last Name:	First Name:	Date of Birth:	
Phone Number:	Email Address:		
Address:	City:	State:	Zip:

FAMILY INFORMATION				
Family is defined as a group of two people or more related by birth, marriage, domestic partnership, or adoption and residing together.				Family Size:
Name <i>(include name of applicant)</i>	Date of Birth	Relationship to Applicant	Total gross monthly income <i>(if 18 years of age or older)</i>	BestCare client?
				Yes No
				Yes No
				Yes No
				Yes No

INCOME INFORMATION	
Income information is required for all family members 18 years of age or older. Below is a list of proof of income documentation that we accept; documentation must be provided for every income source. If you are unable to provide documentation, you may submit a signed statement describing your income.	
<ul style="list-style-type: none">• Last year's income tax return• W-2 statement• Current pay stubs (minimum of 2 months)• Signed statements from employer	<ul style="list-style-type: none">• Approval/denial of eligibility for unemployment compensation• Approval/denial of TANF, Food Stamps, or other entitlement services which show calculated income
If you have no income, please speak to a staff member, or call the Billing Department at 541-516-4087.	

PATIENT AGREEMENT
I understand that BestCare Treatment Services may verify the information I am submitting to assist in determining eligibility for financial assistance. I affirm that the information on this application is accurate to the best of my knowledge and understand that if the information I submit is determined to be false, it may result in denial of financial assistance and I may be responsible to pay appropriate fees for services provided.

Applicant Signature

Date

Application Due Date