RADIATION ONCOLOGY CARE
AT MERIDIAN PARK

Financial Assistance Application

You must Complete the Following Information:

Head of House Hold: _____

Patient Name: _____ DOB: _____

Address: _____ City_____ State____ Zip Code _____

Home Phone (___) _____ Cell Phone (___) _____ Wk Phone (___) _____

Number of People in the Immediate Family: _____

Name:	SSN:	Name:	SSN:
Name:	SSN:	Name:	SSN:
Name:	SSN:	Name:	SSN:
Name:	SSN:	Name:	SSN:
Name:	SSN:	Name:	SSN:

6489 S.W. Borland Rd. Tualatin, OR 97062
☎(503) 692-4843 🖷 (503) 692-6543

RADIATION ONCOLOGY CARE
AT MERIDIAN PARK

Please Complete:

	WEEKLY	MONTHLY	ANNUALLY
Gross Pay Check (s)			
Social Security Benefits			
Veterans Benefits			
Public Assistance			
Contributions from Relatives			
Child Support			
Alimony			
Other			

You Must Attach the Following:

1) 2 Recent Paycheck Stub or Copy: Date: _____ Date: _____

2) 2 Most Recent Bank Statement or Copy: Date:_____ Date: _____

3) Most Recent Federal Tax Return Date: _____

4) List of Monthly Expenses:

I affirm that all of the information in this document is true, correct and complete to the best of my knowledge. This information is being submitted to Radiation Oncology Care at Meridian Park as part of my financial assistance request. .

Signature: _____ Date: _____

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