Financial Assistance Application

Dear Patient/Responsible Party,

We are providing this application because you may qualify for our ***Financial Assistance Program.***

The attached form only applies to bills of the hospital and its employed physicians. For a list of included physicians please review our Financial Assistance Policy, Appendix A. This form does not pertain to any other medical bills you may have, such as radiology, non-employed physicians, ambulance, etc.

In order to be considered for a full or partial assistance, you **must** complete the Financial Assistance Application. The responsible party **must sign** the bottom, and return the completed application.

It is necessary for you to provide us with **your latest Federal Tax Return** for supporting documentation. If you did not file a tax return, please indicate and attach any two of the documents listed below.

State Income Tax Return
Employer paystubs
Written documentation from income sources
Copies of all bank statements for the past three months
Supporting W-2
Supporting 1099s

If, for any reason, you cannot provide us with the requested information, please attach a written statement explaining why you cannot provide the information requested.

For any assistance in completing the application or to return the completed application in person please see one of our Financial Counselors at the below address:

OU Medical Center
711 Stanton L. Young Blvd., Suite 100
Oklahoma City, OK

OUMC Edmond
1 S Bryant Ave.
Edmond, Ok 73034

Please allow thirty (30) business days for our review process. We will notify you of our charity determination by letter.

If you return this form your bill may be included in our Financial Assistance Program.

Mail application and all required documents to:
Patient Account Services
Attn: Dallas SSC
PO Box 290489
Nashville, TN 37229-0489

OU Medicine

Financial Assistance Application

Hospital Name_____ Account Number_____
Patient Name_____ Social Security Number_____
Responsible Party Name_____ Social Security Number_____
Address _____ Phone Number _____

Dependents in Household

(This includes spouse, children under 18 and all others claimed on your tax return)

Name (First, middle and last name if different than Patient) — Age

_____ ____
_____ ____
_____ ____

Employment (Patient/Responsible Party)

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Spouse Employment

Employer Name_____ Hourly Rate_____ Hours Worked Per Week_____
Current Gross Weekly, Monthly or Yearly Income (Before Taxes)_____
If unemployed, date last worked_____

Other Income

	Patient	Spouse
Social Security		
Pension		
Unemployment		
Worker's Compensation		
VA Benefits		
Rental Income		
Stocks, Bond, 401(k)		
Dividend/Interest		
Child Support		
Alimony		
Other		

Have you applied for Medicaid or any other State/County assistance? _____
If yes and known, case number_____ Date applied_____

I, the undersigned, certify that I am eligible for financial assistance because I am the person responsible for payment of amounts that may be due because of services provided. I further certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application and to assist in determining whether I am qualified for financial assistance. I understand that falsification of information or failure to complete all fields submitted may jeopardize my consideration for the program. **Mail to: Patient Account Services, Attn: Dallas SSC, PO Box 290489, Nashville, TN 37229-0489**

Signature:_____ Date:_____

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