GREAT PLAINS REGIONAL MEDICAL CENTER
1801 W 3RD ST, ELK CITY, OK, 73644

FINANCIAL ASSISTANCE APPLICATION

INSTRUCTION:

1. COMPLETE THE APPLICATION AND RETURN TO GREAT PLAINS REGIONAL MEDICAL CENTER, PO BOX 2339, ELK CITY, OK 73648 BY THE DATE LISTED BELOW
2. INCLUDED THE FOLLOWING DOCUMENTATION WHEN YOU RETURN THE APPLICATION
    a. If all documentation is not with application then the application will be voided and the Responsible party will be responsible for the balance(s) due.

DOCUMENTS NEEDED:

A. (3) MONTHS OF PAY STUBS BOTH HUSBAND AND WIFE IF APPLICABLE

B. (3) MONTHS OF BANK STATEMENTS

C. COPY OF ALL UTILITIES (ELECTRIC, GAS, WATER/SEWER, PHONE, CABLE/DIRECT TV)

D. COPY OF MOST RECENT FILED INCOME TAX RETURN

RETURN DATE (14 DAYS FROM RECEIPT) LISTE DATE: _____

IF YOU HAVE ANY QUESTIONS CALL OUR PATIENT ADVOCATE NUMBER OF: (580)821-5519

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Responsible Party Personal and Employment Information

First Name _____ Last Name _____ Date of Birth _____ Social Security Number _____

Home Address (Include Apt #) _____ City _____ State _____ Phone Number _____

Employer's Name _____ Position _____ Employer's Address _____

Employer's Phone # _____ Employment Length _____ Monthly Gross Salary (Paycheck Stub Included) _____

Spouse First Name _____ Last Name _____ Date of Birth _____ Social Security Number _____

Employer's Name _____ Position _____ Employer's Address _____

Employer's Phone # _____ Employment Length _____ Monthly Gross Salary (Paycheck Stub Included) _____

***If there is no income for party(s) applying for Medical Financial Assistances, a notarized proof of living conditions and any financial assistance the party(s) are presently receiving from other sources then those mentioned in this document is required from the person(s) giving the assistances.

IF THE RESPONSIBLE PARTY(S) ARE NOT EMPLOYED PLEASE CIRCLE ONE: DISABLED RETIRED STUDENT
IF YOU ARE A FULL TIME SUTUDENT, PLEASE LIST NAME OF SCHOOL _____ PHONE # _____

OTHER SOURCE OF INCOME (PLEASE INDICATE MONTHLY AMOUNT(S))

Monthly Social Security Checks $ _____ Alimony/Child Support $ _____

Pensions (must list each separately)
1. _____
2. _____
3. _____

Interest/Dividends (must list each separately)
1. _____
2. _____
3. _____

Unemployment $ _____ Rental Income (House, etc.) $ _____ Public Assistance $ _____

Other Income (Explain) _____

_____

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PROPERTY YOU OWN (INCLUDING HOME DWELLING, LAND, UNDEVELOPED LAND, ETC.)

Property # 1_____ **LOCATION OF PROPERTY:**_____

VALUE OF PROPERTY: $_____ **AMOUNT OWED ON PROPERTY: $**_____

Property #2_____ **LOCATION OF PROPERTY:**_____

VALUE OF PROPERTY: $ _____ **AMOUNT OWED ON PROPERTY: $** _____

AUTOMOBILES

VEHICLE #1: MAKE _____ **, MODEL** _____**, YEAR** _____**, BALANCE OWED $**_____

VEHICLE #1: MAKE_____ **, MODEL** _____**, YEAR** _____**, BALANCE OWED $**_____

BANKING INFORMATION

NAME OF BANK _____

CHECKING ACCOUNT NUMBER _____ CURRENT BALANCE $_____

SAVING ACCOUNT NUMBER _____ CURRENT BALANCE $ _____

IRA ACCOUNT/RETIREMENT ACCOUNT _____ CURRENT BALANCE $_____

LIST IF THERE ARE ANY DIFFERENT FINANCIAL INSTIUTITION YOU DEAL WITH:

_____

_____

_____

LIST DEPENDENT(S)

LIST DEPENDENT CHILDREN AND IF THE DEPENDENT IS ACTIVE ON A STATE FUNDED INSURANCE SUCH AS MEDICAID

	NAME	RELATIONSHIP	BIRTH DATE	STATE FUNDED INS YES OR NO
1.				
2.				
3.				
4.				

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MONTHLY OBLIGATIONS

MONTHLY EXPENSES

RENT/HOUSE PYMTS: $_____ **ENTERTAINMENT: $** _____ **ELECTRIC/HEAT: $**_____

CAR INSURANCE: $_____ **HOME/RENT INS: $** _____ **WATER/SEWER: $**_____

DOCTOR/DENTIST/PRESCRIPTION: $_____ **FOOD/HOUSEHOLD SUPPLIES: $**_____

CLOTHING: $_____ **CELL PHONE: $**_____ **CABLE/DIRECT TV: $** _____

FUEL FOR VEHICLE: $_____ **SCHOOL SUPPLIES: $**_____ **BOOKS/MAGAZINE SUB: $**_____

MEDICAL INS: $ _____ **LIFE INSURANCE: $**_____ **CAR MAINTENANCE: $** _____

OTHER EXPENSES (EXPLAIN): $ _____

TOTAL MONTHLY OBLIGATIONS: $_____

CREDITOR(S) INFORMATION (EXAMPLE: CREDIT CARDS, AUTO LOAN, MEDICAL EXPENSSES) ATTACH COPIES OF MEDICAL EXPENSES

	NAME OF CREDITOR	TYPE OF CREDITOR	AMOUNT OF LOAN	BALANCE DUE	MTHLY PMT
1.			$	$	$
2.			$	$	$
3.			$	$	$
4.			$	$	$
5.			$	$	$
6.			$	$	$
7.			$	$	$
8.			$	$	$

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- I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.
- I agree to notify the provider of service within 10 days if there are any changes in income, property, expenses in the household or any change of address.
- I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with financial institution, credit verification and property search
- I understand that a copy of my credit report will be obtained at the time of my application to verify any and all statements given on this application
- I understand that any information given or obtained is kept confidential
- I understand that if I do not qualify for medical financial assistances, I will be personally liable for the charge(s) of service(s) rendered by Great Plains Regional Medical Center or I may appeal the decision in writing with additional documentation
- I understand that I will make application for any and all assistance which may be available through federal, state and local sources as well as any private sources who will assist in paying the hospital for the service(s) rendered and I will provide proof of any such application
- I understand that this application will be completed and returned with all required documentation within 14 days of receipt of application.
- I understand I will be notified via letter within 30 days from turning this application with all required documentation attached to the Business Office if I was granted full Financial Assistance, partial financial assistance.

_____ _____

Applicant Signature Date

_____ _____

Signature of Spouse Date

For Office Use Only

Application was given on: _____ **By:** _____

Application was returned on: _____ **Received By:** _____

Reviewed by: _____

Approved for: 100% **Patient owes $0.00**

80% **Patient is responsible for: $**_____

60% **Patient is responsible for: $**_____

50% **Patient is responsible for: $**_____

Application was denied: give reason _____

_____

Letter of approval or denial was sent on: _____ **By:** _____

Application is good until: _____