To Our Valued Patient:

Thank you for choosing Eastern Oklahoma Medical Center for your healthcare needs. Enclosed you will find an application for hospital financial assistance. This is for covered financial assistance services only.

Patients with a family income at or below 300% of the applicable federal poverty guideline who lack sufficient funds to pay their bills may be eligible for assistance. Patients with significant medical bills regardless of income may also be eligible for assistance. In addition to partial or full adjustments, assistance includes extended payment arrangements.

Upon receipt of a completed application, our staff will conduct a review of the application for possible assistance towards the balance on your account(s). We will notify you in writing after our review.

If you have any questions regarding the application or the above information, please contact a hospital financial counselor or call the number listed below.

Please return this page and the completed application and provide all supporting documentation to the hospital business office. Supporting documentation may include the following:

- Most recent and complete Income Tax Return
- 3 most recent paycheck stubs (additional info may be requested)
- 3 most recent checking/savings account statements
- Food Stamp or SSI/SSA/SSD award letter
- If you report a $0 income, please attach a brief explanation of how you or the patient are meeting basic needs

Sincerely,

Jennifer Perez Admitting Supervisor
918-635-3302
Monday – Friday
8:00 AM to 5:00 PM

Please return completed applications to:
Eastern Oklahoma Medical Center
105 Wall Street
Poteau, OK 74953

Application Date: _____ Guarantor Name (if applicable): _____

Patient Name: _____ Date(s) of Service: _____

Hospital Account #(s) _____

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RESPONSIBLE PARTY INFORMATION			
Responsible Party Name:		Relationship to patient:	
Date of birth:	SSN:		Phone:
Current address:			
City:	State:		ZIP Code:
Own Rent (Please circle)	Monthly payment:		How long?
Previous address:			
City:	State:		ZIP Code:
Owned Rented (Please circle)	Monthly payment or rent:		How long?
Number of People in Household:			Number of Dependents (under 21):
Patient Name:			Patient DOB:
US Citizenship: Y / N	Legally Blind: Y/ N	Nursing Home Resident: Y/ N	Crime Victim: Y /N
Pregnant: Y / N	Pending SSI/Food stamp/Medicaid/Disability Application: Y / N		
Account Number(s):			

HOUSEHOLD INCOME			
Type	**Responsible Party Amount**	**Spouse or Other Resident Amount**	**Type of Verification Required**
Employment Income (Gross)	$	$	Ü Provide paycheck stubs for the last 3 pay periods or 3 months of bank statements
Self-Employment Income (Gross)	$	$	ü Provide 3 months of bank statements
Pension, Retirement, Social Security Income	$	$	ü Provide your Pension/Retirement statement, and/or SSI award letter
Unemployment, Disability Income, ect	$	$	ü Provide unemployment, disability award letter, or 3 months bank statements
Child Support, Alimony	$	$	ü Provide copy of divorce decree, or child support award documents
Other:_____	$	$	ü Provide 3 months of bank statements

ASSETS		
Type	**Financial Institution**	**Total Balance Amount/Worth**
Cash	$	$
Savings Account(s)	$	$
Checking Accounts(s)	$	$
Stocks or Bonds	$	$
401(k) / IRA	$	$
House	$	$
Vehicles other than primary vehicle	$	$
Boats/ATVs/Recreational Vehicles	$	$
TOTAL ASSETS	$_____	

MONTHLY EXPENSES		
Type	**Monthly Payment**	**Amount Due**
House Payment/Rent	$	$
House Insurance	$	$
Other Properties		
Property Tax	$	$

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Utilities		
Electricity	$	$
Water	$	$
Gas	$	$
Telephone/Cellular	$	$
Cable/Satellite/Internet	$	$
Alimony/Child Support	$	$
Child Care Costs	$	$
Car Insurance Premiums	$	$
Health Insurance Premiums	$	$
Groceries	$	N/A
	Subtotal $_____	$
Vehicle Payment(s)		
	Subtotal $	$
Credit Card/Loan Payment(s)		
		$
Outstanding Medical Bills (List)		
	Subtotal $	$
TOTAL EXPENSES		

I certify that above information to be accurate and complete. I understand that the hospital reserves the right to verify all information supplied. I agree to notify the hospital's Financial Services Department of any change in my financial information within 30 days of the change. I understand that this application does not relieve me of my financial responsibility for charges at Eastern Oklahoma Medical Center.

	Date:
Signature of applicant	
	Date:
Witness/Translator (if applicable) Signature	
	Date:
Signature of Hospital Representative	