



And Rural Health Clinic

100 South Ellis, Boise City, Oklahoma 73933
580-544-2501

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Date

FINANCIAL ASSISTANCE / CHARITY CARE APPLICATION

Name of Patient:	
Patient's Date of Birth:	Patient's Social Security Number:
Mailing Address:	
Daytime Phone Number:	Alternate Phone Number:
Employers's Name and Phone Number:	

HOUSEHOLD INFORMATION:

LIST ALL MEMBERS OF YOUR HOUSE HOLD WHO WERE CLAIMED ON YOUR MOST RECENT IRS FORM

Names:	Relationship to Patient	Age
Total number of household members (including the patient):		

Do you have health insurance:..... Yes No

If YES, please enclose a front and back copy of your insurance card(s)

Did you apply for Medical Assistance in the past 6 Months?..... Yes No

If YES, please enclose a copy of the Letter of Denial or proof of eligibility

If NO, please contact your local assistance office for guidance on how to apply for these benefits.

Are you or any of your household eligible for any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Subsidized School Lunch Program | <input type="checkbox"/> Low Income Subsidized Housing |
| <input type="checkbox"/> State Funded Prescription Program | <input type="checkbox"/> WIC |
| <input type="checkbox"/> Food Stamps | |

If **YES**, please provide documentaion verifying eligibiliy

Do you or any members of your household have a bank account?..... Yes No

Check the types of accounts you have:

- | | | |
|--|---|----------------------------------|
| <input type="checkbox"/> Checking | <input type="checkbox"/> Certificate of Deposit (CDs) | <input type="checkbox"/> Savings |
| <input type="checkbox"/> Health Savings accounts (HSAs) | | <input type="checkbox"/> Other |

If **YES**, Please provide the most recent 3 months on each account for each household member having money accounts.

Do you or any members of your household receive benefits from:

- | | |
|--|---|
| <input type="checkbox"/> Social Security | <input type="checkbox"/> Unemployment |
| <input type="checkbox"/> Pension or retirment income | <input type="checkbox"/> Workers Compensation |
| <input type="checkbox"/> Alimony or Child Support | <input type="checkbox"/> Other income |

If **YES**, please provide documentaion verifying benefits.

Disclaimer: I understand that the information I provide will be used only to determine financial responsibility for my charges at Cimarron Memorial Hospital and Rural Health Clinic, and will be kept confidential. I understand that the materials I send to prove my income will not be returned. I further understand that the information which I submit concerning my annual family income and family size is subject to verification by Cimarron Memorial Hospital and Rural Health Clinic. I uderstand that my full cooperation with the Financial assistance and Charity Care Application process is required in order to be considered for benefits of this program. I understand that I will be financially liable for any charges for my medical services not covered through Financial Assistance and Charity Care. I agree to set up a payment plan on for the outstanding balance. I understand that if any information I have given is determined to be false, it may result in reversing the application approval and I will be liable for the full amount of all charges.

Signature:	Relationship to Patient:	Date:
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