CIMARRON MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

We're here to help.

Cimarron Memorial Hospital understands that unexpected medical expenses can create financial hardship. **If you are unable to pay for medically necessary healthcare services, you may qualify for Financial Assistance.**

Please complete this application as accurately as possible. Completion of this application does not guarantee eligibility for Financial Assistance.

Need help completing this application? Please ask a member of our Registration or Business Office staff. We will be happy to assist you.

SECTION 1 - PATIENT INFORMATION

Patient Name	
Date of Birth	
Medical Record Number (if known)	
Account Number(s) (if known)	
Street Address	
City / State / ZIP	
Telephone	
Email	
Preferred Contact	☐ Telephone ☐ Mail ☐ Email

SECTION 2 - HOUSEHOLD INFORMATION

List each person who lives in your household, including the patient.

Name	Relationship	Date of Birth
otal Household Members		

SECTION 3 - HOUSEHOLD INCOME

Enter estimated gross monthly income before taxes or deductions for all household members.

Income Source	Monthly Amount
Wages	$
Self-Employment	$
Social Security	$
Retirement or Pension	$
Unemployment	$
Other	$
TOTAL GROSS MONTHLY INCOME	**$**

SECTION 4 - INSURANCE INFORMATION

Do you have health insurance?	☐ Yes ☐ No
Insurance Company	
Policy Number	
Have you applied for Medicaid?	☐ Yes ☐ No ☐ Pending

SECTION 5 - SUPPORTING DOCUMENTATION

Provide copies of available documents that support the income reported above. Check all documents included:

- ☐ Most recent federal income tax return
- ☐ W-2
- ☐ Two recent pay stubs
- ☐ Social Security benefit statement
- ☐ Pension or retirement statement
- ☐ Unemployment benefit documentation
- ☐ Other: _____

If you cannot provide the requested documentation, explain why:

_____

_____

SECTION 6 - ADDITIONAL INFORMATION

Describe any circumstances you would like the Hospital to consider, including extraordinary financial hardship:

_____

_____

_____

SECTION 7 - CERTIFICATION AND AUTHORIZATION

I certify that the information in this application is true and complete to the best of my knowledge. I authorize Cimarron Memorial Hospital to request or verify information needed to determine eligibility. False or misleading information may result in denial or reversal of Financial Assistance.

Applicant Signature	
Printed Name	
Date	
Relationship to Patient (if applicable)	

HOSPITAL USE ONLY

Date Received	
Received By	
Application Complete	☐ Yes ☐ No
Additional Information Requested	☐ Yes ☐ No
Date Forwarded to Business Office	

Attach the Financial Assistance Determination Form after Business Office review.

CIMARRON MEMORIAL HOSPITAL

WHAT HAPPENS NEXT?

Thank you for submitting your Financial Assistance Application. We understand that discussing financial concerns can be difficult, and we appreciate the opportunity to review your request.

1	**Application Review** Our Business Office will review your application to make sure the required information has been received.
2	**Additional Information** If information is missing, we will send you a written request. Please provide the requested information within 30 calendar days.
3	**Eligibility Review** Once complete, your application will be reviewed under the Hospital's Financial Assistance Policy and Adjustment Schedule.
4	**CEO Review** The recommendation will be reviewed by the Chief Executive Officer to help ensure the program is administered consistently and fairly.
5	**Written Determination** You should generally receive a written determination within approximately 15 business days after we receive a completed application.

If Your Application Is Approved

The applicable Financial Assistance adjustment will be applied to your account. You will receive a letter explaining the adjustment and any remaining balance.

If Your Application Is Not Approved

You will receive a written explanation. You may request reconsideration by submitting additional supporting information within 30 calendar days of the determination letter.

Questions or Need Help?

Contact the Cimarron Memorial Hospital Business Office

Phone: (580) 544-2501 Ext 1 | Hours: M-F 9:00 – 5:00

Our Commitment to You

Our goal is to treat every patient with dignity, respect, fairness, and compassion while responsibly managing the resources entrusted to our Hospital.