Weatherford Regional Hospital
Managed by SSM Health | St. Anthony Hospital

FINANCIAL ASSISTANCE APPLICATION

Return information to:
MAIL: Weatherford Regional Hospital
3701 E. Main St.
Weatherford, OK 73096

FAX: 580-774-0964

YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Weatherford Regional Hospital determine if you may receive free or discounted services or are eligible for other public programs that may help you pay for your health care.

INSTRUCTIONS FOR COMPLETING THIS FORM:
Please fill this form out completely and return with all required documentation. Financial assistance will not be awarded to those who do not complete the application process, including the requirement for the patient to apply for programs for which they may qualify (i.e. Medicaid).

Please submit this application with the following documentation:

1. **Copies of your current federal tax return with all schedules (including W-2s) or Proof of Non Filing (IRS Form 4506)**
2. **Household income verification as required below in the "Household Monthly Income" section**
3. **Proof of Medicaid denial, if eligible -- apply at http://www.okhca.org/individuals.aspx (Online Enrollment)**

PATIENT NAME	DATE OF BIRTH	ACCOUNT #S
Responsible Party/Guarantor Name	Date of Birth	Social Security Number
Relationship to Patient	Home Phone	Cell Phone
Current Address	Own/Rent?	City, State, Zip
Employer Name/Address		Work Phone
Spouse Name	Date of Birth	Social Security Number
Employer Name/Address	Work Phone	Cell Phone

Additional Household Members

Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Other Information

1. Does your employer (or spouse's employer) offer group health insurance?	Y / N	If Y, list insurance company below
2. Do you have other types of insurance that may pay medical bills?	Y / N	If Y, list insurance company below
3. Do you have a Health Savings/Flex Spending Account?	Y / N	If Y, what is the balance amount $ _____
4. Does your employer reimburse you for any deductible or healthcare costs?	Y / N	
5. Were you denied for Medicaid?	Y / N	If Y, please attach copy of Medicaid denial
6. Are you eligible for COBRA through a previous employer?	Y / N	If Y, list insurance company below
7. Was the patient involved in an alleged accident that led to the need for services?	Y / N	
8. Was the patient a victim of an alleged crime that led to the need for services?	Y / N	

Household Monthly Income

Type	Responsible Party		Spouse	Type of Income Verification Required
Employment Income (Gross)	$		$	Provide paycheck stubs for the last two pay periods or 3 months of bank statements
Self Employment Income (Gross)	$		$	Provide 3 months bank statements
Pension, Retirement, Social Security Income	$		$	Provide your Pension/Retirement statements and/or Social Security award letter
Unemployment, Disability Income	$		$	Provide unemployment, disability award letter, or 3 months bank statements
Child Support, Alimony	$		$	Provide a copy of your divorce decree, legal separation notice, or custody agreement
Other (please list source) _____	$		$	Provide 3 months bank statements with an explanation of your income source(s)

Assets		
Type	Financial Institution	Total Balance (approximate as accurately as possible)
Cash		$
Checking Account(s)*		$
Savings Account(s)*		$
Stocks or Bonds*		$

* Provide 3 months bank statements or Stock/Bonds statements

Please explain any situation we should be informed of in order to understand your inability to pay the medical balance. You may attach a separate sheet if more space is needed. Additional verification may be required.

I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.

Responsible Party Signature_____ Date_____

WRH BO USE ONLY

Checklist of required information to complete application process:

- [ ] Front and back of form completely filled out with signature and date
- [ ] Copies of current federal tax return with all schedules including W-2s (or Proof of non-filing--IRS Form 4506)
- [ ] Items required in Household Income Verification section

Date All Items Received by WRH Business Office _____

WRH Representative _____

Date Final Application Reviewed:_____ By: _____

Level of Approved Financial Assistance for Non-elective Medically Necessary Services: _____

Date Range of Approval: _____

Financial Assistance Denied: _____

Denial Reason: _____

Notifications Sent:

Patient	_____	Solutions	_____	Hospitalists	_____
AMS	_____	ER Physicians	_____	Other	_____