Date: _____

Due Date: _____

Patient Name: _____ Hospital Account #(s): _____

Guarantor Name: _____ _____

Date(s) of Service: _____ _____

MMG Account #: _____ _____

Dear Patient:

Attached you will find the Comanche County Memorial Hospital Financial Assistance Application. Completion of this application will enable us to present your account(s) for consideration of financial assistance for your Comanche County Memorial Hospital and/or Memorial Medical Group bill(s).

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will only be shared within Comanche County Memorial Hospital on a need to know basis.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application.

It is extremely important that you complete this application upon receipt and return it with all the supporting documents within 30 days of the date on this letter.

If you have difficulty completing this application or there is an area that is unclear, please feel free to contact Comanche County Memorial Hospital Business Services at (580) 357-9984.

Your cooperation is appreciated.

Sincerely,

***Comanche County Memorial Hospital Business Services***

Return Completed application to:

Comanche County Memorial Hospital Business Services

3811 W Gore Blvd Ste 2

Lawton, OK 73505

Comanche County Memorial Hospital

# Application for Financial Assistance

## Section I. General Information

| **Patient Name (Last, First, Middle)** | | **Date of Birth** | **Social Security #** | |
|---|---|---|---|---|
| **Guarantor (*if patient is under 18)*** | | **Date of Birth** | **Social Security #** | |
| **Address** | **City** | **State/Zip Code** | **County** | **Phone Number** |
| **Marital Status:** ☐ Married ☐ Single ☐ Divorced ☐Widowed<br>☐ Seperated ☐Other<br>Is patient the guarantor? ☐ Yes ☐ No | | | US Citizen ☐ Yes ☐ No<br>Passport ☐Yes ☐ No<br>Travel Visa ☐ Yes ☐ No | |
| No. of dependents claimed on taxes, includes Patient: _____ | | Are you employed? ☐ Yes ☐No<br>If No, list the last date of employment: _____ | | |

**Legal dependants as claimed on your taxes:**

Spouse: _____ Age: _____ SSN: _____ - _____ - _____

Child: _____ Age: _____ SSN: _____ - _____ - _____

Child: _____ Age: _____ SSN: _____ - _____ - _____

Child: _____ Age: _____ SSN: _____ - _____ - _____

Do the dependants live in your home?

☐ Yes

☐ No

## Section II. Insurance Coverage

**1.** Do you have insurance / Cobra? ☐ Yes ☐ No

**1a.** Name of insurance company: _____

**1b.** Insurance policy/member #: _____

**2.** Have you and/or family member applied for Medicaid within the last 30 days? ☐ Yes ☐ No

**2a.** When did you apply? _____

**2b.** Name of applicant. _____

☐Pending, Caseworker's name: _____

☐Approved. Medicaid #: _____

☐Denied. (Must provide a copy of Medicaid Denial letter.)

**3.** Have you applied for Social Security Disability? ☐ Yes ☐ No

**3a.** When did you apply?

**4.** Are you receiving short term or long term disability? ☐ Yes ☐ No

**5.** Is your treatment the result of an accident? ☐ Yes ☐ No

***If no, skip to section II. (If yes, please answer questions below.)***

***If yes, application will not be processed until liability has been resolved (please obtain copies of accident details.)***

**6.** Have you filed Underinsured motorist coverage? ☐ Yes ☐ No

**7.** Have you filed Uninsured motorist coverage? ☐ Yes ☐ No

**8.** Have you filed Personal Injury Protection (PIP) insurance? ☐ Yes ☐ No

**9.** Have you filed Workers Compensation? ☐ Yes ☐ No

**10.** Are you represented by an attorney? ☐ Yes ☐ No

***If no, skip to section II. (If yes, please provide below information.)***

**10a.** Attorney Name: _____ Attorney's Number: _____

Comanche County Memorial Hospital

## Section III. Income/Assets/Expenses

| Income/Assets (Monthly) | Patient (Monthly) | Spouse (Monthly) | Expenses (Monthly) | Other (Monthly) |
|---|---|---|---|---|
| Wages (Must provide last 3 paystubs): | $ | $ | Rent/Mortgage: | $ |
| Social Security*: | $ | $ | Home Insurance: | $ |
| Unemployment*: | $ | $ | Utilities: | $ |
| Foodstamps*: | $ | $ | Cable/Internet: | $ |
| Housing Assistance*: | $ | $ | Telephone: | $ |
| Workers' Compensation*: | $ | $ | Health Insurance: | $ |
| Child Support*: | $ | $ | Child Care: | $ |
| Alimony*: | $ | $ | Credit Cards: | $ |
| Military Allotment*: | $ | $ | Loans: | $ |
| Pensions*: | $ | $ | Food: | $ |
| Rental Property*: | $ | $ | Prescriptions: | $ |
| Income from*: (CD's, Stocks, Investments, Retirement funds, etc) | $ | $ | Other: | $ |

***Must provide supporting documents. Award letter, court orders, etc.)***

**Total Monthly Income: $** _____

**Total Monthly Expenses:** _____

**11.** Do you or your spouse own a checking account? ☐ Yes ☐ No Checking account balance : $ _____
***If no, provide notarized letter.***
***If yes, provide the last 3 month's detailed bank statement.***

**12.** Do you or your spouse own a savings account? ☐ Yes ☐ No Savings account balance : $ _____
***If no, provide notarized letter.***
***If yes, provide the last 3 month's detailed bank statement.***

**13.** Do you own a business? ☐ Yes ☐ No Value of business: $ _____
***If no, skip to section III.***
***If yes, you will need to submit a copy of your business and personal tax return for the most recent filing year. Please include copies of schedule C and/or K)***

## Section IV. Housing/Real Estate/Other Property Information

**14.** Do you own your home? ☐ Yes ☐ No Monthly Mortgage Payment : $ _____

**15.** Do you rent your home? ☐ Yes ☐ No Monthly Rental Payment : $ _____

**16.** Do you live in someone else's home? ☐ Yes ☐ No

**16a.** Name and relationship of the person you are living with. _____

**17.** Do you own any of the following (Please check all that is applicable):

☐ Rental/Income Property ☐ Land ☐ Recreational Vehicles

Address for rental/income property and/or land:

_____

**18.** Does anyone in the home own a vehicle? ☐ Yes ☐ No
***If no, please provide a notarized letter stating what method of transportation you receive. (If yes, please provide below information.)***

**18a.** Make/Model of Vehicle(s): _____ Mileage of vehicle(s): _____

## Section V. Check list

***Did you remember to include copies of the following?***

- ☐ Entire copy of Federal Tax Return or letter of non-filing from IRS. (*this does not include W-2 forms)*
- ☐ Last 3 paystubs for everyone in the home over 18 or notarized letter stating you are unemployed
- ☐ Social Security Award Letter
- ☐ Medicaid Award or Denial Letter
- ☐ Award letters for any assistance received. (*Food stamps, Housing Assistance, Lifeline Telephone Services, etc.)*
- ☐ Last 3 bank statements or notarized letter stating you do not own an account. (*Must be detailed bank statements. Summary statements are not accepted.)*

***Please send copies only. ORIGINALS WILL NOT BE RETURNED.***

*I certify that the answers written above and any additional information and/or income I have listed are true to the best of my knowledge. I understand that Comanche County Memorial Hospital may verify the financial information contained in this application and hereby authorize the hospital to contact my employer to certify the information and to request reports from credit reporting agencies. I give my Social Security number voluntarily and have permission to provide the Social Security numbers of other eligible dependents listed above. I understand that Comanche County Memorial Hospital may use my Social Security numbers for the purpose of accurate identification, filing insurance claims, billing, collections in compliance with Federal and State laws. I am aware that any falsification of information in this may result in the denial or possible reversal of Charity Assistance. <u>This application must be completed and all supporting documents returned in order to process. If it is not, it may be returned to the patient for completion or automatically denied.</u>*

PATIENT OR GUARANTOR SIGNATURE _____ DATE _____

SPOUSE OR CO-APPLICANT SIGNATURE _____ DATE _____