McBRIDE
ORTHOPEDIC HOSPITAL
INTEGRIS HEALTH

Dear Patient:

Attached you will find the McBride Orthopedic Hospital (MCBOH) Financial Assistance Program Application. Completion of the form will enable us to consider the need for financial assistance for your medical bill(s). Applications must be resubmitted every six months and must include total household income and total number of persons residing in the household.

To protect your right to privacy, all documents received will be treated as confidential information and except for verification purposes, will NOT be shared with anyone outside of MCBOH.

Please complete each item on the form. If you need additional space for any explanations, please utilize the back of the application. A credit report may be obtained to verify information provided. **Photographed documents will not be accepted.** All documentation provided shall become the property of MCBOH and cannot be returned to you.

Copies of all items listed below that are applicable to you must be provided so that a determination can be made for assistance. **Self-prepared taxes using a tax preparation software are not accepted.**

- ❑ Entire copy of the Previous Year Tax Transcript. (*Do not include W-2 forms or pay stubs*).
  - (Go to www.irs.gov or call 1-800-908-9946 to obtain your Official IRS Transcript).
- ❑ Social Security Award Letter. (*Include proof of spouse's income, if applicable*).
- ❑ Physician Disability Statement listing a permanent disability with documentation.
- ❑ Self Employed: Copy of most recent filed personal federal income tax return and a current profit and loss statement, including all schedules that apply.
- ❑ Non-Filers: Provide IRS Verification of Non-Filing letter.
- ❑ Any other documentation, as requested, to process your application.

It is important that you complete this application upon receipt and return it within 15 days. The application will be reviewed within **30** days of receipt and you will be notified via letter of a decision made within **60** days.

If you have any difficulty completing this application or have any questions, please contact our office by phone at (405) 486-2385 or by email at MCBOHFinancialAssistance@mcboh.com. Office hours are Monday-Friday 8:00am-5:00pm. Your cooperation is appreciated.

Respectfully,

MCBOH Business Office

McBRIDE
ORTHOPEDIC HOSPITAL
INTEGRIS HEALTH

FINANCIAL ASSISTANCE APPLICATION
RETURN DATE: _____

All information provided will be held confidential according to our privacy policy.

PATIENT NAME:_____

APPLICANT'S RESPONSIBILITY – Please read and sign
I certify that the provided information is correct and I hereby authorize McBride Orthopedic Hospital (MCBOH) to verify all provided information and I authorize any third party to release to MCBOH any information required to verify and authenticate this application.

I understand that in order to process this application, additional information may be needed and it must be provided by me when requested. I understand that failure to do so will result in an automatic denial.

MCBOH is authorized to check my credit history and to report to others its credit experience with me.

Health Insurance:
I understand that health insurance takes precedence over financial assistance. I understand all insurances must first be filed and resolved before financial assistance can be applied.

I understand that my health insurance company may request additional information in order to process my claim. I understand that if I do not provide the requested information and it results in denial of payment by the insurance company, my request for financial assistance will be denied and I will be responsible for payment of all charges of rendered services.

Third Party Liability:
I understand that if this hospitalization is for treatment of an injury, illness, or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, that any claims by me against the third party and/or any recovery by me from the third party will take precedence over financial assistance and any financial assistance rendered will be void. I understand I will then be responsible for payment for all charges of any covered services.

_____ _____
Applicant's Signature Date Spouse / Significant Other Signature Date

PART A

APPLICANT INFORMATION: If patient is under 18, the applicant must be a parent or guardian.

First Name:_____ MI:_____ Last Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Phone: (___)_____

Previous address, if at current address less than 1 year:

_____

PART B

INDIVIDUAL HOUSEHOLD MEMBERS: List everyone in the household, including yourself.

Relation to You	Name	Birth Date	Social Security # (18 & over only)	Does this person receive: Food Stamp		Medicaid, If yes, ID#	
1. **SELF**				Y	N	Y	N
2.				Y	N	Y	N
3.				Y	N	Y	N
4.				Y	N	Y	N
5.				Y	N	Y	N
6.				Y	N	Y	N
7.				Y	N	Y	N
8.				Y	N	Y	N

PART C

Does the applicant receive <u>SOCIAL SECURITY SUPPLEMENTAL SECURITY INCOME (SSI)</u>
(applies only to the patient): Send a copy of your Social Security benefits letter that states you are entitled to Supplemental Security Income (SSI) benefits.

PART D

To qualify for financial assistance with **<u>FOOD STAMP OR MEDICAID BENEFITS:</u>**
The person with the food stamp or Medicaid benefits must either be the applicant or listed on the benefit letter stating that you are entitled. Proof may be required.
<u>Food Stamps:</u> Send a copy of your most current DHS food stamp verification letter.
<u>Medicaid/SoonerCare:</u> Send a copy of your most recent Medicaid/SoonerCare approval letter. **NOTE:** Family Planning, Mental Health and Substance Abuse benefits are not qualifiers.

Only <u>Title 19,</u> <u>S.L.M.B.</u> and <u>QUA-1</u> are qualifying benefits.

If you answered **YES to PART C or D – GO TO PART E.**
If you answered **<u>NO</u> to PARTS C and D – GO TO PART F.**

PART E

If you answered **<u>YES</u> to PART C OR D.**
SIGN THE APPLICANT'S RESPONSIBILITY ON PAGE 1 and provide the required documentation.

****STOP** DO NOT FILL OUT PART F**

PART F

HOUSEHOLD FINANCIAL INFORMATION.
Without this information and documents we will not be able to review your request for financial assistance.

<u>EMPLOYMENT</u>

<u>Applicant</u>: Employer: _____
Start Date (if less than one year): _____ Estimated Gross Monthly Income: $ _____
How often are you paid: ❑ Weekly ❑ Bi-weekly (every other week) ❑ Semi-monthly (twice a month) ❑ Monthly
Are you paid by: ❑ Bank Account Direct Deposit ❑ Check ❑ Debit Card

<u>Spouse</u>: Employer: _____
Start Date (if less than one year): _____ Estimated Gross Monthly Income: $ _____
How often are you paid: ❑ Weekly ❑ Bi-weekly (every other week) ❑ Semi-monthly (twice a month) ❑ Monthly
Are you paid by: ❑ Bank Account Direct Deposit ❑ Check ❑ Debit Card

❑ Self-Employed: Name of Business: _____
Address: _____ Phone: (_____)_____