Harper County Community Hospital Financial Assistance Application

Dear Patient:

As part of our commitment to serve the community Harper County Community Hospital elects to provide financial assistance to individuals who satisfy certain income requirements.

To determine if a person may qualify for financial assistance, we need to obtain certain financial information as Outlined within this application. Your cooperation will allow us to give all due consideration to your request for financial assistance.

Please complete the Financial Assistance Application and return the completed from to our business office or mail to the following address:

Harper County Community Hospital PO Box 60 Buffalo OK 73834

You will continue to receive statements and attempts to collect this debt will continue until such time that the application is approved for assistance.

Below please find the instructions for completing the financial application. Should you need assistance in completing the form, feel free to contact us at (580) 735-2555.

Any consideration or potential approval of assistance applies ONLY to services provided by Harper County Community Hospital and is not related or applied any way to any physician bills whether by your attending physician or any consulting, pathologist, radiologist or any other physician which may be involved in your care.

Section A: Wages

In section A of the Financial Assistance Application, please indicate the **Dollar Amount** each listed person receives as compensation and whether the amount represents hourly, weekly, monthly, or yearly compensation. Persons in the household include patient, spouse, life partner and others contributing to the household income.

Section B: Other Resources

In the first blank in Section B of the Financial Assistance Application, please indicate the **Dollar Amount** you have invested in checking accounts, savings accounts, stocks, trust funds etc. In the second blank please indicate the **Dollar Amount** of income you receive yearly from such investments. For example, in the first blank one might put that they have $5,000 in a savings account and in the second blank they might put that they earn $250.00 interest yearly on that account.

Section C: Household Members

Section C of the financial Assistance Application requests information on the number of persons in the patient's household. This number should include the patient, the patient's spouse and the patient's dependents or any other person living in the household providing any support. If the patient is a minor, please include the patient, the patient's mother and /or father and/ or legal guardian and any Resident Dependents of the patient's mother and/ or father, and / legal Guardian and / or significant other.

Section D: Income Verification

In order to consider your request for financial assistance, verification of the wages reported in Section A of the Financial Assistance Application is required. Please provide a last 2 years tax returns, most recent pay stubs, bank statements and proof of participation in a public benefit program such as Social Security,

Unemployment Compensation, Medicaid, County Indigent Health Program, AFDC, Unemployment Insurance, Food Stamps, WIC, or other similar indigence related programs.

If you are unable to provide one of the sources of income documentation listed above, please provide a written explanation in Section D of the Financial Assistance Application.

Section E: Medical Expenses

In order to determine your qualification for financial assistance, copies of all medical expenses for the patient and family members incurred during the last 12- months will need to be provided. All medical expenses can be used to qualify, not just hospital charges.

For assistance in completing this application, please contact us at (580) 735-2555 Monday through Friday between the hours of 8:00 an- 5:00 pm.