Mangum Regional Medical Center

Charity Care/Financial Assistance Application Form – confidential

Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed

PRESUMPTIVE ELIGIBILITY CHARITY SCREENING – 100% CHARITY

Has the patient applied for Medicaid? ☐ Yes ☐ No
May be required to apply before being considered for financial assistance

Does the patient receive state public services such as TANF, Basic Food, or WIC? ☐ Yes ☐ No

Is the patient currently homeless? ☐ Yes ☐ No

Is the patient deceased and no known estate to pay for hospital bills ☐ Yes ☐ No

Is the patient incarcerated for a felony ☐ Yes ☐ No
(verified on OSCN.net website)

Patient / Guarantor has received Medicaid benefits. ☐ Yes ☐ No
If so, Eligibility Date: _____
Service dates for up to one-year, previous accounts with dates of service prior to the Medicaid qualification eligibility date, and six months past the Medicaid eligibility date (accounts will be considered for Financial Assistance).

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.
- Within 30 calendar days after we receive your completed application and documentation, we will notify you if you qualify for assistance

APPLICANT INFORMATION

Patient First Name:	Patient Middle Name:		Patient Last Name:
□ Male □ Female □ Other (may specify _____)	Birth Date:		Social Security Number:
Person Responsible for Paying Bill	Relationship:	Birth Date:	Social Security Number:
Mailing Address: _____ City State Zip Code		Main contact number(s): (H) _____ (M) _____ Email Address: _____	

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Employment status of person responsible for paying bill

□ Employed (date of hire: _____)

□ Unemployed (how long unemployed: _____)

□ Self-Employed □ Student □ Disabled □ Retired □ Other (_____)

FAMILY INFORMATION

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

FAMILY SIZE _____ Attach additional page if needed

NAME:	DATE OF BIRTH:	RELATIONSHIP TO PATIENT:	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

All adult family members' income must be disclosed. Sources of income include, for example:

- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI - Child/spousal support - Work study programs (students) - Pension - Retirement account distributions

INCOME VERIFICATION

REMEMBER: You must include proof of income with your application.

You must provide information on your family's income. Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. If you cannot provide documentation, you may submit a written signed statement describing your income. Please provide proof for every identified source of income.

Examples of proof of income include:

- A "W-2" withholding statement; or
- Current pay stubs (2 months); or
- Last year's income tax return, including schedules if applicable; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for Medicaid and/or state-funded medical assistance; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with an explanation.

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EXPENSE INFORMATION

We use this information to assist in the review of your financial situation

Monthly Household Expenses Total: $_____

Rent/mortgage $_____ Medical expenses $_____

Insurance Premiums $_____ Utilities $_____ Other

Debt/Expenses $_____ (child support, loans, medications, other)

INCOME INFORMATION

This information may be used if your income is above 200% of the Federal Poverty Guidelines.

Current Monthly Gross Income:
$_____

Current checking account balance:
$_____

Current savings account balance:
$_____

Does your family have these other assets?

Please check all that apply

□ Stocks □ Bonds □ 401K □ Health Savings Account(s) □ Trust(s) □ Property (excluding primary residence) □ Own a business

ADDITIONAL INFORMATION

Please provide and attach additional page(s) if there is other information about your current financial situation that you would like to include, such as a financial hardship, seasonal or temporary income, or personal loss

PATIENT / GUARANTOR AGREEMENT

I understand that Mangum Regional Medical Center may verify information by reviewing credit information and obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

I affirm that the above information is true and correct to the best of my knowledge. I understand if the information I give is determined to be false, the result will be denial of financial assistance, and I will be responsible for and expected to pay for services provided.

_____ _____

Signature of Applicant Date