WAGONER COMMUNITY HOSPITAL Phone 918-485-1265 Fax 918-485-1295

Financial Assistance Program (FAP) Application

Return within **14 days** to: Attn: FAP, 1200 West Cherokee, Wagoner, OK 74467

"Incomplete" applications **cannot** be considered for financial assistance.

1. **Patient's Name** ____________________
   Date of Birth ____________________ Social Security # ____________________
   Spouse's Name ____________________
   Date of Birth ____________________ Social Security # ____________________
   Full Address ____________________
   Telephone ____________________ Cell or 2nd ____________________
2. Employer (Self) ____________________
   Name Address Phone Number
   Employer (Spouse) ____________________
   Name Address Phone Number

MINOR INFORMATION (If the patient is a child)

3. Guarantor Name ____________________
   Date of Birth ____________________ Social Security # ____________________
   Address (If different from patient) ____________________
   Employer ____________________
   Name Address Phone Number
4. **Family Members Residing in Household** other than Patient and Spouse

Name (first and last)	*Relationship*	*Age*

Attach separate sheet to list more members

REQUIRED DOCUMENTATION:

___ **1.** Copy of one of the following that applies to you:
(a) Federal Income Tax: complete return for last year (include all pages of return)
(b) IRS Form 4506-T Non-Filing Verification
(c) Social Security Administration Form SSA-7004 Request for Statement.

___ **2**. Copy of Checking/Savings Account Bank Statement, dated within the last 30 days.

___ **3.** Copy of most recent paycheck stub with year-to-date earnings, or **Award Letter** showing government benefits (social security, SSI, Food Stamps etc.)

___ **4.** Completed FAP application (this form) with signature.

___ **5.** Copy of most recent Rent or Mortgage Receipt.

___ **6.** Copy of most recent Utility Bills.

___ **7.** Copy of Medical Bills, if seen at other facilities for catastrophic illness.

SECONDARY PAYER SOURCES: Are you eligible:

___ Title 19 (Medicaid) ___ Indian Agency assistance ___ Auto insurance ___Crime victim

Please explain:____________________

INCOME: List All Income for Household	**Monthly**	**Yearly**
Wages (Gross Income before Taxes)	$______________	$_________________
Farm or Self-Employed	______________	_________________
Public Assistance ___Food Stamps ___VA	______________	_________________
___TANF ___Other	______________	_________________
Social Security/Supplemental Social Security	______________	_________________
Unemployment or Worker's Compensation	______________	_________________
☐ Alimony and/or ☐ Child Support	______________	_________________
Pension/Retirement Income	______________	_________________
Income from Dividends, Interest, Rent, Etc.	______________	_________________
Other Income: ____________________________	______________	_________________
TOTALS:	$______________	$_________________

"IF THERE IS NO INCOME, FROM WHERE DOES YOUR SUPPORT COME?"

____

Please Itemize Other Current Medical Expenses-Copies Required

Name of Health Care Provider ***other than*** *Wagoner Community Hospital*	*Balance Due*
____	$______________
____	$______________
____	$______________

List other extenuating financial obligations that you wish to be considered on separate sheet.

We may require additional documentation in order to assist you. If so, we will contact you at the address or telephone numbers you have listed. Patients who fail to follow through in the application process may be denied financial assistance.

I hereby state the information given in this application is true, correct and complete to the best of my knowledge. I authorize any required verification. I also authorize Wagoner Community Hospital to request reports from credit reporting agencies and the Social Security Administration to verify the information that I have provided. I understand that false or misleading information may result in denial of financial assistance.

I understand that this request for financial assistance pertains **only** to Wagoner Community Hospital. Charges from Providers other than those employed by Wagoner Community Hospital itself are not covered by the hospital's FAP. Those providers may include: Eagle Partners, V-Rad, Tulsa X-ray Lab, Spectrum Imaging (radiologist), Southwest Pathology, Physicians: Drs. Jewell Daniels, Barry Farmer, Eric Massad, Craige Brestel, Chelsea McGee, Michael Chamberlain, Kammie Caldwell, Carolyn Garcia, John Belk, Dennis Rivero, Clinton Baird, Brian Rich, Premier Anesthesia Management, Farmer Family Practice, Valerie Pack, Jerry Cole, Meredith Woodward.

Our FAP program is designed for emergent care events. If approved, I understand that I will be required to submit a new FAP application on an annual basis. Also, I understand that each event that creates charges will be evaluated for approval on a case by case basis. Non-emergent events, i.e. Surgery, MRI and CT scans would require pre-approval and may not be approved even if you had been previously approved for an emergent event.

Patient/Guardian's Signature____ **Date**___________________

Please retain a copy of this application for your records. This application will not be returned to you.