

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

<i>Name (first and last)</i>	<i>Relationship</i>	<i>Age</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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 <u> </u> Food Stamps <u> </u> VA	_____	_____
<u> </u> TANF <u> </u> Other	_____	_____
Social Security/Supplemental Social Security	_____	_____
Unemployment or Worker's Compensation	_____	_____
<input type="checkbox"/> Alimony and/or <input type="checkbox"/> 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 <u>other than</u> 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 facility charges. Physician or other professional services are no longer eligible for FAP consideration. This includes not only Wagoner Community Hospital physician charges but may also include any or all charges from Providers other than those employed by Wagoner Community Hospital. Those providers may include: V-Rad, Tulsa X-ray Lab, Southwest Pathology, Clinical Pathology Laboratories. Physicians: Dr. Jewell Daniels, Dr. Barry Farmer, Dr. Eric Massad, Dr. Craig Brestel, Dr. Chelsea McGee, Dr. Kammie Caldwell, Dr. John Belk, Dr. Clinton Baird, Premier Anesthesia Management, Farmer Family Practice, and Dr. Paula Guinnip.

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.