Dear Patient / Guarantor,

We are presently reviewing your account. To review this account for Financial Assistance we are requesting the following documents:

A. A completed Financial Assessment Application.
B. Copy of your last year's tax return and your most recent statement for all checking and savings accounts.
C. Copy of your most recent four-week period of pay stub(s), unemployment check(s), Social Security Benefit Statement(s), and/or Pension/Retirement Benefit Statement for household.
D. Letter of Support; if you are receiving financial, housing, food/clothing and/or other support from family, friends, and/or an organization other than your spouse.
E. If you receive government subsidized housing, SNAP (food stamps), or any member of your immediate family has SoonerCare/Medicaid, please provide proof of these documents as well.

These items are necessary to document your financial conditions and for us to process your request for assistance.

Please return the requested items as soon as possible. You may call (918) 494-6500 if you have any questions. You will be contacted if any additional information is needed and also to inform you of the decision made. Thank you for choosing Saint Francis Health System for your healthcare needs.

Return to:
Attn: Financial Counseling
Saint Francis Health System
6161 S Yale Ave
Tulsa, OK 74136

Sincerely,
Saint Francis Health System
Patient Financial Services

PATIENT NAME IN FULL | ☐ M ☐ F | AGE | DATE OF BIRTH

ARE YOU A CITIZEN OF THE UNITED STATES ☐ Yes ☐ No | RESIDENT OF OKLAHOMA ☐ Yes ☐ No | HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID) ☐ Yes ☐ No | IF YES, INDICATE MONTH | YEAR

ARE YOU OR YOUR SPOUSE SELF-EMPLOYED ☐ Yes ☐ No | DID YOU FILE A FEDERAL TAX RETURN ☐ Yes ☐ No | STATE TAX RETURN ☐ Yes ☐ No | DO YOU HAVE THIRD-PARTY INSURANCE COVERAGE ☐ Yes ☐ No

ARE YOU ENROLLED IN THE EXCHANGE PROGRAM

☐ Yes ☐ No - *If no, why not?*

## RESPONSIBLE PARTY INFORMATION

| APPLICANT | APPLICANT'S SPOUSE |
|---|---|
| NAME | NAME |
| ADDRESS | CITY / STATE / ZIP CODE |
| PHONE NUMBER ( ) / CELL PHONE ( ) | PHONE NUMBER ( ) / CELL PHONE ( ) |
| SOCIAL SECURITY NUMBER | SOCIAL SECURITY NUMBER |
| EMPLOYER | EMPLOYER |
| IF UNEMPLOYED, LAST DATE WORKED | IF UNEMPLOYED, LAST DATE WORKED |
| DATE LAST CHECK RECEIVED | DATE LAST CHECK RECEIVED |

## FAMILY AND PATIENT INFORMATION

**FAMILY MEMBERS LIVING IN THE HOME**

| NAME | DATE OF BIRTH | AGE | RELATIONSHIP | SOCIAL SECURITY NUMBER |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## FAMILY INCOME
List Amounts of Each

**Patient**

| | | | | |
|---|---|---|---|---|
| SALARY / WAGES / TIPS | INTEREST / DIVIDENDS | ALIMONY | SOCIAL SECURITY | PENSION / RETIREMENT |
| DISABILITY | UNEMPLOYMENT | WORKERS COMP | SELF EMPLOYMENT - ATTACH SCHEDULE C | |

**Spouse**

| | | | | |
|---|---|---|---|---|
| SALARY / WAGES / TIPS | INTEREST / DIVIDENDS | ALIMONY | SOCIAL SECURITY | PENSION / RETIREMENT |
| DISABILITY | UNEMPLOYMENT | WORKERS COMP | SELF EMPLOYMENT - ATTACH SCHEDULE C | |

## FAMILY RESOURCES
List Present Value

| | | |
|---|---|---|
| Checking Account(s) | | |
| Savings Account(s) | | |
| IRA / 401K / 430B | | |
| Food Stamps (list amount received) | WIC ☐ No ☐ Yes (Need Qualifying Letter) | LOW INCOME HOUSING ☐ No ☐ Yes (Need Qualifying Letter) |

PROPERTY (HOUSE OR PERSONAL PROPERTY OTHER THAN YOUR RESIDENCE) - *DESCRIPTION AND LOCATION* | MARKET VALUE $

IS THIS HOSPITAL SERVICE / PHYSICIAN SERVICE A RESULT OF A PERSONAL INJURY/ACCIDENT CASE FROM WHICH YOU EXPECT TO RECEIVE A SETTLEMENT ☐ Yes ☐ No | IF YES, EXPECTED AMOUNT $

I hereby acknowledge that I have read this document. It has been provided in printed format or explained to me in my native language and was understood. I certify that all information regarding income and assets are true. I understand that the information which I submit concerning my income, assets, liabilities, and family size is subject to verification. I hereby authorize the release of any necessary information from individuals, universities or colleges, businesses, public or private organizations to determine my eligibility. I assign and transfer to Saint Francis Health System all my rights to benefits, monies, and sums payable to me for hospitalization, sickness, or accident liability coverage. I understand that failure to disclose information and/or payments will result in denial of the application.

PATIENT - SIGNATURE | DATE | TIME

PERSON COMPLETING FORM, IF OTHER THAN PATIENT - SIGNATURE | RELATIONSHIP TO PATIENT | DATE | TIME

INTERPRETER / WITNESS - SIGNATURE

DATE | TIME

PATIENT LABEL

SaintFrancis Health System

# FINANCIAL ASSESSMENT APPLICATION