NORMAN REGIONAL
Health System

F/S Income:	MCD	DIS	
100%	90%	80%	70%

FINANCIAL ASSISTANCE APPLICATION
RETURN DATE: _____ or 21 days from date mailed.

All information provided will be held confidential according to our privacy policy.

PATIENT NAME: _____

Account Number

APPLICANT'S RESPONSIBILITY − Please read and sign

I certify that the provided information is correct and I hereby authorize the Norman Regional Health System to verify all provided information and I authorize any third party to release to Norman Regional Health System any information required to verify and authenticate this application.

I understand that in order to process this application additional information may be needed and it must be provided by me when requested. I understand that failure to do so will result in an automatic denial.

Norman Regional Health System is authorized to check my credit history and to report to others its credit experience with me.

Health Insurance:

I understand that health insurance takes precedence over financial assistance. I understand all insurances must first be filed and resolved before financial assistance can be applied.

I understand that my health insurance company may request additional information in order to process my claim. I understand that if I do not provide the requested information and it results in denial of payment by the insurance company, my request for financial assistance will be denied and I will be responsible for payment of all charges of rendered services.

Third Party Liability:

I understand that if this hospitalization is for treatment of an injury, illness, or condition which may have been caused by a third party, for which that third party is, or may be liable for damages, that any claims by me against the third party and/or any recovery by me from the third party will take precedence over financial assistance and any financial assistance rendered will be void. I understand I will then be responsible for payment all charges of any covered services.

Applicant's Signature Date

Spouse / Significant Other Signature Date

SIGNED APPLICATIONS can be MAILED or HAND DELIVERED TO:
Norman Regional Health System, att: PFS, 901 N Porter, PO Box 1308, Norman, OK 73070−1308 or faxed to 405−307−1304.
For e−mail option or questions call 405−307−1318, Option 2

For Patient Financial Services Use Only: Determination: (Initials Only)

Approved: (Circle One) 100% 90% 80% 70% 20% FPG

Date:	Date:	Date:

Denied Reason: Date:

Patient Label

PART A

APPLICANT INFORMATION: If patient is under 18, the applicant must be a parent or guardian.

First Name: _____ MI: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone:(___)_____

Previous address, if at current address less than 1 year:

_____

Name of Nearest Relative not living with you: Name: _____ Relation:_____

Address:

PART B

INDIVIDUAL HOUSEHOLD MEMBERS: List everyone in the household, including yourself

Relation to you	Name	Birth Date	Social Security # (18 & over only)	**Does this person receive:**	
				Food Stamp	**Medicaid, If yes, ID#**
1. **SELF**				Y N	Y N
2.				Y N	Y N
3.				Y N	Y N
4.				Y N	Y N
5.				Y N	Y N
6.				Y N	Y N
7.				Y N	Y N
8.				Y N	Y N

AUTOMATIC QUALIFIERS ** subject to verification
Social Security Supplemental Security Income (SSI), Food Stamp benefits, Medicaid benefits.

PART C

Does the applicant receive SOCIAL SECURITY SUPPLEMENTAL SECURITY INCOME (SSI) (applies **only** to the patient): Send a copy of your Social Security benefits letter that states you are entitled to Supplemental Security Income (SSI) benefits.

PART D

To qualify for financial assistance with **FOOD STAMP OR MEDICAID BENEFITS.**
The person with the food stamp or Medicaid benefits must either be the applicant or listed on the benefit letter stating you are entitled.
Proof may be required.
Food Stamps: Send a copy of your most current DHS food stamp verification letter.
Medicaid/SoonerCare: Send a copy of your most recent Medicaid/SoonerCare approval letter.
Note: Family Planning, Mental Health and Substance Abuse benefits are not qualifiers.
Only Title 19, S.L.M.B. and QUA−1 are qualifying benefits.

If you answered **YES to PART C OR D − GO TO PART E.**
If you answered **NO to PARTS C and D: GO TO PAGE 3.**

PART E

If you answered **YES TO PART C OR D.**
SIGN THE APPLICANT'S RESPONSIBILITY ON PAGE 1 and provide the required documentation.

****STOP** DO NOT FILL OUT PAGE 3**

Patient Label

PART F

HOUSEHOLD FINANCIAL INFORMATION
Without this information and documents we will not be able to review your request for financial assistance.

EMPLOYMENT

Applicant:

Employer: _____
Start Date (if less than one year): _____
Estimated Gross Monthly Income: $ _____
How often are you paid:
❑ Weekly ❑ Bi−weekly (every other week)
❑ Semi−monthly (twice a month) ❑ Monthly
Are you paid by bank account Direct Deposit ❑, Check ❑, Debit card ❑

Spouse:

Employer: _____
Start Date (if less than one year): _____
Estimated Gross Monthly Income: $ _____
How often are you paid:
❑ Weekly ❑ Bi−weekly (every other week)
❑ Semi−monthly (twice a month) ❑ Monthly
Are you paid by bank account Direct Deposit ❑, Check ❑, Debit card ❑

❑ Self−Employed:
Name of Business:
_____
Address: _____
Phone (_____) _____

Monthly Expenses

Housing:
Rent ❑ Own ❑
Rent/House payment:
$ _____
Mortgage balance:
$ _____
Utilities:
Electric $ _____
Gas $ _____
Water $ _____
Food $ _____
Auto:
Payment $ _____
Credit Cards:
_____
_____
_____
_____
Medical Expenses:
_____
_____
_____
_____

****REQUIRED DOCUMENTATION**

Household Income:

******Written verification of your household's income for the past twelve months.
Each household member must be included.
****Paycheck:** Provide a current paycheck for each household member.
****Bank accounts:**
Checking/Savings account: Send three months (90 days) checking account statements and a current savings account statement.
❑ **I do not have a bank account.**
**Instead send a copy of your current house payment/rent receipt and a current utility receipt.
****Federal Income Tax Return:**
Send a copy of your most recent Federal Income Tax return for each wage earner. Send all pages of the return including all Schedules, W2s and 1099s.
❑ ***I did not file income tax for the last year. Signature:*** _____
If you worked any part of the previous tax year and you did not file taxes, send your W2s or Form 1099s.

Students:

****College/University student:**
Also include Financial Aid Notification (FAN) letter, proof of Enrollment
****International Student:** Also include a copy of your Form I−20 provided to your University/College

Comments: _____
_____
_____
_____

Patient Label