

Dear Patient:

Attached you will find the INTEGRIS Health Financial Assistance Program Application. Completion of the form will enable us to consider the need for financial assistance for your medical bill(s). Applications must be resubmitted every year or if requesting a redetermination and must include total household income and total number of persons residing in the household.

To protect your right to privacy, all documents received are treated as confidential information and except for verification purposes, will NOT be shared with anyone outside of INTEGRIS Health.

Please complete each item on the form. If you need additional space for any explanations, please attach supplementary documentation on a separate page. A credit report may be obtained to verify information provided. All documentation provided shall become the property of INTEGRIS Health and cannot be returned to you.

Copies of all items listed below that are applicable to you must be provided so that a determination can be made for assistance.

- Entire copy of the Previous Year Tax Filing Documents.
 - If taxes are self-prepared, must also provide eFile confirmation.
- Social Security Award Letter. (Include proof of spouse's income, if applicable).
- Physician Disability Statement listing a permanent disability with documentation.
- Self Employed: Copy of most recent filed personal federal income tax return and a current profit and loss statement, including all schedules that apply.
- Non-Filers: Provide IRS Verification of Non-Filing letter.
- Any other documentation, as requested, to process your application.

It is important that you complete this application upon receipt and return it within 15 days. The application will be reviewed within 30 days of receipt, and you will be notified via letter of a decision within 60 days.

If you have any difficulty completing this application or have any questions, please contact our office using any of the below methods.

Phone: (855) 409-5458

Fax: (405) 949-9120

Email: INTEGRISHealthFinancialAssistance@integrishealth.org.

In-Person: 5300 N Independence Avenue, Suite 130, Oklahoma City, OK 73112

Office hours are Monday-Friday 8:00am-5:00pm.

Respectfully,

INTEGRIS Health Business Office



Application for Financial Assistance

PATIENT NAME IN FULL			PATIENT DATE OF BIRTH		AGE	SEX M <input type="checkbox"/> F <input type="checkbox"/>		
APPLICATION CATEGORY NEW (FIRST TIME/EXPIRED APPLICATION) <input type="checkbox"/> REDERMINATION (PREVIOUSLY DENIED/LIFE EVENT) <input type="checkbox"/>			HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID)? YES <input type="checkbox"/> NO <input type="checkbox"/>		MARITAL STATUS: SINGLE <input type="checkbox"/> / MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> / WIDOWED <input type="checkbox"/>			
RESPONSIBLE PARTY INFORMATION	PATIENT			SPOUSE or GUARANTOR (for minor patients)				
	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 INFORMATION	FAMILY MEMBERS LIVING IN THE HOME							
	NAME		AGE	DATE OF BIRTH	RELATIONSHIP		SOCIAL SECURITY	
PATIENT AND FAMILY	List Monthly Totals	PATIENT \$		SPOUSE \$		DEPENDENTS \$		PENSION/ANNUITIES \$
		SOCIAL SECURITY \$		DISABILITY \$		SELF EMPLOYMENT - ATTACH SCHEDULE C \$		TOTAL MONTHLY INCOME: \$

I understand that INTEGRIS Health may verify financial information contained in this application in connection with the evaluation of this application, and hereby authorize contact with my employer to certify the information provided and/or request credit report from agencies. I am aware this information will be used to determine my eligibility for financial assistance and falsifications. I certify the information in this application is correct to the best of my knowledge. **This application must be completed to determine eligibility. Incomplete applications may be delayed or declined.** I further understand any reimbursement of medical expenses I receive related to this application must be sent to INTEGRIS Health.

Signature of person making request

Date

Signature of person making request, if not patient

Date