STILWELL MEMORIAL HOSPITAL

FINANCIAL ASSISTANCE APPLICATION

1401 W. Locust St., P.O. Box 272, Stilwell, OK 74960 | 918-696-3101

https://stilwellmemorial.com/financial-assistance/

Important Information

This application is used to determine whether you qualify for financial assistance for emergency or medically necessary services billed by Stilwell Memorial Hospital. You may apply whether or not you have insurance, Medicare, or Medicaid. There is no charge to apply.

Patient Information

Patient Name: _____

Date of Birth: _____

Patient Phone: _____

Current Address: _____

City/State/ZIP: _____

Social Security Number (if required for verification): _____

Responsible Party / Guarantor

Name: _____

Relationship to Patient: _____

Date of Birth: _____

Phone: _____

Address: _____

City/State/ZIP: _____

Social Security Number (if required for verification): _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Spouse Information

Name: _____

Date of Birth: _____

Phone: _____

Address: _____

City/State/ZIP: _____

Social Security Number (if required for verification): _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Other Household Members

List all members of the household whose income is relevant to the financial-assistance determination.

Name	Relationship	Date of Birth	Monthly Gross Income

Insurance and Other Coverage

Do you have health insurance? ☐ Yes ☐ No

Do you have Medicare? ☐ Yes ☐ No

Do you have Medicaid? ☐ Yes ☐ No

Does your (or spouse's) employer offer health insurance? ☐ Yes ☐ No

Does you have other insurance? ☐ Yes ☐ No

Does you have a Health Savings or Flex Spending Account? ☐ Yes ☐ No

Were you denied Medicaid? ☐ Yes ☐ No (attach denial letter)

Is the need for services related to an accident or crime? ☐ Yes ☐ No

Monthly Gross Household Income

Type of Income	Responsible Party	Spouse & Other	Income Verification
Employment Income for ALL HOUSEHOLD MEMBERS (Gross)			Most recent 2 months' paycheck stubs and last 3 months' bank statements
Self-Employment Income (Gross)			
Pension / Retirement Income			
Social Security Income			
Unemployment/Disability Income			
Child Support / Alimony			
Other Income:			

Please attach reasonably requested income documentation, such as recent pay statements, Social Security or disability award letters, a federal income tax return or proof of non-filing, bank statements, investment statements, proof of household income, and information concerning other financial resources. Documentation will be requested in a manner reasonably related to determining eligibility.

Assets and Financial Resources

Type	Financial Institution	Balance
Cash		
Checking Account(s)		
Savings Account(s)		
Stocks or Bonds		
Health Savings or Flex Accounts(s)		
Other Readily Available Financial Resources		

Asset information may be requested when evaluating medical indigence or extraordinary circumstances. An asset that is not reasonably available to pay the Hospital bill will not by itself result in denial.

Special or Extraordinary Circumstances

Please describe circumstances affecting your ability to pay, including extraordinary medical expenses or other significant financial hardship. Attach another page if needed.

_____
_____
_____
_____

Standard Discount Schedule

Household income as % of FPG	Discount
200% or less	100%
201%-225%	80%
226%-250%	60%
251%-300%	40%
301%-350%	20%
Above 350%	No standard FAP discount

Presumptive Eligibility

The Hospital may determine eligibility without a completed application when reliable information supports financial assistance, including certain circumstances such as homelessness, qualifying deceased patients without an estate or responsible party, incarceration without a responsible spouse or other liable party, or recent Medicaid approval.

Certification

I certify that the information provided is true and complete to the best of my knowledge. I authorize Stilwell Memorial Hospital to verify information reasonably necessary to determine eligibility, including credit information when permitted and reasonably necessary for a medical-indigence review. I understand that financial assistance applies only to services covered by the Hospital's FAP and does not guarantee coverage of physician or outside-provider bills.

Responsible Party Signature: _____ Date: _____

Patient/Authorized Representative: _____ Date: _____

Business Office Use Only

Date Received: _____

Application Complete? ☐ Yes ☐ No: _____

FPG Level: _____

Discount: _____

Medical Indigence Review? ☐ Yes ☐ No: _____

Determination Date: _____

Reviewed By: _____

Decision: ☐ Approved ☐ Denied ☐ Presumptive Eligibility

Reason/Notes: _____