Vickey Peugh, Financial Counselor ** PO BOX 2408 ** Stillwater, OK 74076 ** 405-742-5711

STILLWATER MEDICAL CENTER AUTHORITY
FINANCIAL ASSISTANCE APPLICATION
Instruction Sheet

Please be sure to attach a copy of the following to the completed application:

1. Copy of last paycheck stub, Social Security or Disability check stub for all family members that have an income. The paycheck stub must be dated immediately prior to the date of the application. A letter from your employer will be accepted. If only one family member has an income, a letter stating the other person does not work is required.

2. Your family's most recent Federal Income Tax forms. Please **do not** send W2's. If you were not required by law to file, please submit a letter stating that. If you own your own business, include your Profit & Loss statement from your Federal Tax Return. If you can be claimed as a **dependent** on someone else's tax return, we need a copy of that person's tax return and a copy of that person(s) current paycheck stub.

3. Checking and/or Savings account statements (FULL 30 day itemized activity) for previous month from date of application.

4. A copy of the patient's driver's license or picture ID. If the patient is under 18 years old, a copy of a parent's driver's license or picture ID is needed.

5. The insurance information on page 1 of the Application is REQUIRED. If you have no insurance, please report "NONE".

Please answer all of the questions in each section. If a section does not apply to you, please indicate this on the application by stating "Not Applicable". Failure to do so could delay processing of your application or cause a denial of your application. ***This application must be returned with all of the required verification paper work in order to be considered for assistance.***

If you are granted assistance by Stillwater Medical Center Authority, we can only assist with Stillwater Medical Center and Perry Memorial Hospital bills. ***You may have other obligations to Radiology, Pathology, Non-Stillwater Medical Physicians, etc.; however, we may not be able to assist with those debts. Financial assistance does not apply to Cimarron Medical Services.***

Please sign and date application before returning to the Financial Counselor.

Your application will be reviewed upon receipt and a determination will be mailed to you in approximately 8 weeks. If you have any questions, please call **405-742-5711** or email vpeugh@stillwater-medical.org.

Thank you!

Vickey Peugh - Financial Counselor
Stillwater Medical Center
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PO Box 2408
Stillwater, OK 74076
Fax: 405-533-6071

Revised June 2019

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Financial Assistance Frequently Asked Questions

1. **Do I have to provide my spouse's information?**
   Yes, your spouse's current paycheck stub, checking and savings account statements (30 day itemized activity), and most recent Federal Income Taxes are needed to apply for financial assistance.

2. **If I am claimed as a dependent on someone else's Federal Income Taxes, do I have to provide their information?**
   If you were claimed as a dependent on someone else's Federal Income Taxes, then a copy of their Federal Income Taxes is required along with a copy of their most recent paycheck stub.

3. **If I get denied for being over income, how soon can I reapply?**
   You can reapply when there is a change in your financial situation.

4. **Are co-pays eligible for financial assistance?**
   Co-pays are not eligible for financial assistance. Co-pays are intended to be paid at the time of service. They are a part of your contractual arrangement with your insurance company.

5. **If I live with a roommate who pays my rent, do I need to include my roommate's information?**
   If you and your roommate do not file Federal Income Taxes together then their information is not needed. Please note in the additional space provided on the application that you have a roommate who you share the bills with.

6. **Will I receive a new statement after the financial assistance has been applied?**
   A new statement will be mailed after the financial assistance has been applied, on the next billing cycle.

7. **My paycheck is direct deposited to a checking account. Do I have to provide a copy?**
   Even if your paycheck is direct deposited to a checking account and can be seen on the itemized bank statement, a copy of a paycheck stub is needed. If you are unable to obtain a copy of a current paycheck stub from your employer or human resources department, a letter from the employer will be accepted. The letter will need to be on company letter head and have the following information: rate of pay per hour worked, the average number of hours worked in a pay period, how frequently you are paid (weekly, bi-weekly, or monthly), and the contact information for someone with your employer.

8. **Why is my approved discount percentage reduced for some clinic visits?**
   Some Stillwater Medical Center (SMC) clinics provide services as a department of the hospital and other SMC clinics operate as separate individual practices. Financial Assistance Program discounts for our individual practices are half of the percentage approved for hospital based services.

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Financial Assistance Application

Patient Name: _____ Date: _____

Section 1: Applicant

Last Name: _____ First: _____ MI: _____ BIRTHDATE: _____

Address: _____ Home Phone #: _____

City: _____ State: _____ Zip: _____ Work Phone #: _____

Email Address: _____ Cell Phone #: _____

Initial here if you will accept correspondence by email _____

List Household Members	Relationship	Birthdate	Medicaid#	

Section 2: Medicaid

Have you filed for Medicaid?

☐ No
☐ Yes, If Yes denial date: _____

Section 3: List doctors or clinics where services are being received

SMC Doctor: _____

SMC Doctor: _____

SMC Doctor: _____

PMH Doctor: _____

PMH Doctor: _____

Section 4: Health Insurance

Type of policy:

☐ Group
☐ Individual
☐ HMO
☐ Work Comp
☐ Other _____

Name of Insurance: _____

Address for Submission of claims: _____

Policy #: _____ Policy Holder SSN: _____ Group #: _____ Coverage Begins Date: _____
Coverage Ends Date: _____

Policy Holder's Name (last, first): _____ Address: _____

Policy Holder's Employer Name: _____ Address: _____

Relationship to patient:

☐ Self
☐ Father
☐ Mother
☐ Other:_____

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Section 5: Employment

Name of Applicant's Employer: _____ Work Phone #: _____

Address: _____

Name of Spouse's Employer: _____ Work Phone #: _____

Address: _____

Section 6: Calculating Income

	Current Monthly Amount	
Applicant's Income:	$	(Gross)
Spouse's Income	$	(Gross)
Child Support:	$	
Alimony:	$	
SSI:	$	
Family Support:	$	
Parental Support:	$	
Retirement Pension:	$	
Food Stamps:	$	
Section 8:	$	
	$	
Total Income:	$	

Section 7: Assets

	Vehicle #1	Vehicle #2
Make:		
Model:		
Year:		
Mileage:		
Current Value:	$	$
Amount Owed:	$	$

Please provide any additional information you feel would be helpful to be used in determining your eligibility for assistance:

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Section 8: Expenses

Expense	Monthly Payment		Current Value	Amount Owed
Auto Insurance:	$	Real Estate:	$	
Auto Loan:	$	Checking Accts:	$	
Auto Maintenance & Gas:	$	Savings Accts:	$	
Credit Cards:	$	CD's:	$	
Groceries:	$	IRA's/Retirement Accounts:	$	
Loans	$	Stocks/Bonds:	$	
Rent/Mortgage:	$	Other:	$	
Telephone:	$		$	
Utilities:	$		$	
Total All Expenses:	$	Total Assets:		

Do you and/or your spouse have a checking account?

☐ No
☐ **Yes, If Yes- attach a complete 30 day itemized activity statement**

Do you and/or your spouse have a savings account?

☐ No
☐ **Yes, If Yes- attach a complete 30 day itemized activity statement**

Did you file Federal Income Taxes?

☐ No
☐ **Yes, If Yes- attach a copy of your 1040 income tax return**

Were you claimed as a dependent on anyone's Federal Income Taxes?

☐ No
☐ **Yes, If Yes- attach a copy of their 1040 income tax return and a current copy of their paycheck stub**

Do you and/or your spouse receive any income from an employer?

☐ No
☐ **Yes, If Yes- attach a copy of your and/or your spouse's most recent pay stub**

Please provide any additional information you feel would be helpful to be used in determining your eligibility for assistance:

_____

_____

_____

_____

_____

_____

CONFIRMATION STATEMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information provided to complete this application is true. I authorize Stillwater Medical Center Authority to use any information contained in the application to verify my eligibility for this program, and to obtain records pertaining to eligibility from a financial institution or from any insurance company. This information may also be released for the purpose of acquiring financial assistance among other creditors (i.e.: surgeon, radiology, and anesthesiology).

Print or Type Applicant Name: _____ Applicant Signature: _____

Date: _____

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