Choctaw
Memorial
Hospital

Dear Patient:

You may be eligible for medical care even if you cannot pay for it.

Choctaw Memorial Hospital has a Charity Care Program for patients who cannot afford to pay for medically necessary care. Eligibility for the program is based on your family's income and the number of people in your family. It may also be based on whether your medical expenses would constitute a medical hardship.

In order to be considered for care you need but cannot pay for, please complete the attached application form. If you have any questions or need assistance in completing this application, please contact our Collections Specialist at (580) 317-9500. If you cannot complete the form, you may have an authorized representative fill it out for you.

Please fill out the forms completely. Choctaw Memorial Hospital will also need the following:

1. Valid, current IDENTIFICATION
    a. State or Federal issued Photo I.D. (driver's license, state ID, Green Card, passport)
    b. Proof of residency of Choctaw County for the previous year (2 required). i.e. phone or utility bill, rent receipts/lease, trash)

2. INCOME: (Please provide all income for everyone residing in household) for the last 90 days.
    a. Copy of complete FEDERAL TAX return from the previous year
    b. IRS form W2 (only if taxes have not been filed)
    c. Paycheck Stubs
        i. SSA/SSI award letter stating current amount being received from social security
        ii. Proof of payments from pension plans
        iii. Proof of unemployment (UIB) benefits, if applicable for patient and spouse.
    d. Notarized letter of survival (how are you living) from the person(s) supporting the patient who is requesting financial assistance, if the patient is not working

3. BANK/CREDIT UNION STATEMENTS from the last 3 months on all accounts
    a. Checking

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b. Savings
c. Investments, including stock and bonds
d. Trust funds
e. Money Market accounts
f. Mutual funds
g. Other investment funds that will not incur a penalty for early withdrawal

4. INSURANCE VERIFICATION
    a. A copy of all current Insurance Cards, including Medicare, Medicaid and CICP, or a letter stating you choose not to carry health insurance.
    b. A copy of any other discount programs cards, such as Doctor's Care or healthcare co-op or cost sharing health plans, etc.
    c. Acceptance letter into any other external charity program for medical expenses.
    d. Any crowd/funding websites, social media accounts, or bank sponsored charity/gift fund set up to solicit funds to pay for expenses.

Please send your application to:
Choctaw Memorial Hospital
Collections Specialist
1405 E Kirk St.
Hugo, OK 74743

We will notify you within thirty (30) business days as to whether your Charity Care Application has been approved.

If you are denied Charity Care, you may: 1) appeal the denial; 2) re-apply for Charity Care at any time if your financial situation changes; or 3) work out a payment plan with our Collections Specialist, considering your existing financial obligations.

Thank you

Appendix B
Charity Care Application Form

1. Applicant Information:

Last Name First Name MI	Charity Care Sequential Control Number (CCSN, completed by Choctaw Memorial Hospital)
Street Address	Telephone Numbers Home:_____ Work: _____ Cell: _____
City State Zip Code	Mailing Address (if different from Street Address)
Date of Birth	____ Male ____ Female / Are you pregnant? Yes___ No___

Are you: **Homeless?** **Yes___** **No___**
Unemployed? **Yes___** **No___**
Uninsured? **Yes___** **No___**

2. If you are applying for someone else, please complete this section:

Last Name First Name MI	Relationship to Applicant:
Street Address	Telephone Numbers Home:_____ Work: _____ Cell: _____
City State Zip Code	Mailing Address (if different from Street Address)

3. **Family Information:** List the people in your family who live with you and you support with your income. Include your spouse, dependent children under age 18 and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child's parent or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M___ F___	Y___ N___
			M___ F___	Y___ N___
			M___ F___	Y___ N___
			M___ F___	Y___ N___

4. **List Earned Income** before taxes and deductions for each family member who works:

Name of Working Family Member	Employer Name & Address	Amount Earned	How Often? Weekly / Monthly / Annually

5. Other Income not from an employer:

Type of Income	Family Member Receiving Income	Amount	How Often? Weekly/Monthly/Annually
Social Security			
Railroad Retirement			
Veterans' Benefits			
Retirement Funds			
Annuities			
Pensions			
Child Support			
Alimony			
Unemployment			
Workers Compensation			
Rental Income			
Trust Income			
County General Relief			
Refugee Resettlement Program			
Dividend Income			
Bank Account Income			
Other Income, please specify			

6. Assets:

Type of Asset	Estimated Value	Mortgage Balance
Personal Residence		
Other Real Estate		
Bank Accounts Checking Savings		
Retirement Accounts IRA Other		
Stocks and Bonds		

7. **Other Expenses:** Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family in a nursing home.

Payment Type	Recipient Name / Relationship	Amount Paid	How Often? Weekly/Monthly/Annually
Alimony			
Child Support			
Personal Needs Allowance			

8. **Other Insurance:** Charity Care can pay for such things as your co-payments and deductibles even if you have other insurance.
   a. Are you covered under any health insurance program, including Medicare? Y___ N___

Policy Holder (Name)	Insurance Company	Policy Number

If yes:

b. Are you seeking Charity Care because of a work-related accident or injury? Y___N___
c. Are you seeking Charity Care because of a car accident? Y___ N___
d. Are you a student? Y___ N___ If yes, are you fulltime?___ part time?___
e. Do you have an application pending for any of these programs? *(Check all that apply)*
   Medicaid ___
   Medicare ___

f. Are you currently approved for Charity Care at another hospital or community health center? Y___ N___ If yes, where? _____

9. **Medical Bills:** Total medical bills _____

10. **Assignment of Rights:** *(Read this section carefully and sign)*

I agree to tell Choctaw Memorial Hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Charity Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

I understand that Choctaw Memorial Hospital cannot share confidential information with any state or federal agency without my prior approval.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Authorized Representative Date

If you have any questions about this application, contact the Collections Specialist at (580) 317-9500.

Mail or deliver the completed application to:

Choctaw Memorial Hospital
Attn: Collections Specialist
1405 E Kirk St
Hugo, OK 74743