



APPLICATION FOR FINANCIAL ASSISTANCE

- St. John Medical Center Jane Phillips Medical Center
- St. John Broken Arrow Jane Phillips Nowata
- St. John Owasso St. John Clinic
- St. John Sapulpa

DATE ISSUED	PATIENT NAME
DATE DUE	RETURN TO
P.A.N.	
Complete both sides of application and return, along with a copy of: - your Federal tax return(s) for last year - your most recent paycheck stub(s) - your most recent bank statement	

APPLICANT/RESPONSIBLE PARTY (NAME)		SPOUSE'S NAME			
ADDRESS		CITY	STATE	ZIP	
TIME AT PRESENT ADDRESS	<input type="checkbox"/> Rent <input type="checkbox"/> Own	HOME PHONE ()	NUMBER OF HOUSEHOLD MEMBERS	NUMBER OF ADULTS IN HOUSEHOLD	NUMBER OF MINORS (INCLUDING COLLEGE STUDENTS)

DEMOGRAPHIC INFORMATION		
	APPLICANT	SPOUSE
Employed By		
Business Phone	()	()
Occupation		
How Long Employed		
Hourly Wage		
Social Security Number		

GROSS INCOME (BEFORE TAXES)		
	APPLICANT MONTHLY INCOME	SPOUSE MONTHLY INCOME
Employment Income		
Retirement/Pension		
Social Security		
Worker's Compensation		
Unemployment		
Disability		
Veteran's Benefits		
Public Assistance		
Interest Dividends		
Rental Income		
Child Support		
Alimony		
TOTAL	\$	TOTAL \$

ASSETS/SAVINGS		
	LOCATION	AMOUNT/VALUE
Checking		
Savings		
Certificate of Deposit (CD)		
Stocks/Bonds		
IRAs		

ASSETS/PROPERTY			
MOTOR VEHICLE	YEAR/MAKE/MODEL	LOAN BALANCE	ASSESSED VALUE
	YEAR/MAKE/MODEL	LOAN BALANCE	ASSESSED VALUE
RECREATIONAL VEHICLES/BOATS	YEAR/MAKE/MODEL	LOAN BALANCE	ASSESSED VALUE
	YEAR/MAKE/MODEL	LOAN BALANCE	ASSESSED VALUE
HOMESTEAD (YOUR HOME)	NAME OF MORTGAGE COMPANY	LOAN BALANCE	ASSESSED VALUE

MONTHLY EXPENSES			
MORTGAGE OR RENT EXPENSE	RENTER'S/HOUSE INSURANCE	PHONE	CABLE TV/SATELLITE
ELECTRIC	NATURAL GAS	WATER/SEWER	FOOD
CAR PAYMENT	CAR INSURANCE	RECREATIONAL VEHICLE/BOAT	ALIMONY
CHILD SUPPORT	CHILD CARE	OTHER (LIST)	TOTAL \$

CHARGE ACCOUNTS/OTHER EXPENSES				
LIST CHARGE ACCOUNT AND OTHER DEBTS*			BALANCE	MONTHLY PAYMENT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
			TOTAL	\$

*Attach additional sheet if necessary

MEDICAL EXPENSES				
LIST MEDICAL DEBTS*			BALANCE	MONTHLY PAYMENT
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
			TOTAL	\$
			GRAND TOTAL OF MONTHLY EXPENSES	\$

*Attach additional sheet if necessary

AUTHORIZATION FOR ASSET		
<p>I, _____ authorize St. John Health System to obtain an asset verification. This is deemed necessary to complete the Charity Care Application. I/We hereby certify that the information submitted is correct and authorize you to obtain relevant credit information.</p>		
APPLICANT'S SIGNATURE _____	SOCIAL SECURITY NUMBER _____	DATE _____
SPOUSE'S SIGNATURE _____	DATE _____	

FINANCIAL ASSISTANCE GUIDELINES

Enclosed you will find the Financial Assistance Application you requested. The application must be completed in its entirety and signed before the application will be reviewed. In order to qualify for Financial Assistance, you must apply at your local county Medicaid office for Soonercare. A copy of their approval / denial letter must be mailed to this office before we can consider your Financial Assistance Application. (If you have private insurance, receive Social Security benefits due to disability, or are over the age of 65 you will not need to apply for Soonercare.)

If you have Indian Health benefits, the Indian Agency will need to be notified of your admission, and their payment or denial applied to your account before Financial Assistance can be processed.

You must provide a copy of your latest Federal Tax Return, proof of income, (copy of recent paycheck stub, child support payment, etc.) and a copy of your bank account statements from all bank accounts in your name, which would include any Annuities, IRA accounts, CD's or 401K. If you cannot supply these items, you must explain in writing what means of support you are receiving to pay for your expenses.

If you are receiving Social Security, please provide a copy of your letter indicating the amount you receive each month.

If you are unemployed, we will need a signed, notarized letter stating how long you have been unemployed.

This application pertains to all St. John Health System facilities, including St. John Clinic. Patient requested private room charges and convenience item charges may not be covered by this application.

Please return application to:
1923 S Utica Ave.
Tulsa, OK 74104
Attn: Financial Assistance

Sincerely,

Financial Assistance
St. John Health System
(918) 744-2451