St. John | Ascension

APPLICATION FOR FINANCIAL ASSISTANCE

DATE ISSUED	PATIENT NAME
DATE DUE	RETURN TO

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

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 _____Years_____Months ☐ Rent ☐ 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 additonal 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

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.

_____ _____ _____

APPLICANT'S SIGNATURE SOCIAL SECURITY NUMBER DATE

_____ _____

SPOUSE'S SIGNATURE DATE

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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 for SoonerCare at your local County Medicaid Office. 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 you 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.

Financial assistance provided by St. John Health System to patients is only to assist in covering required patient payment for services provided at a facility owned or operating by a wholly-owned subsidiary of St. John Health System or provided by a physician who is an employee of St. John Clinic. Financial assistance awarded by St. John does not apply to services provided by independent physicians or facilities that are not owned or operated by St. John Health System. Patient requested private room charges and convenience item charges may not be covered by this application. If you have questions pertaining to these requirements, please call the Financial Counseling Office at (918) 744-2451.

Please return application to:

St. John Medical Center
1923 S. Utica Ave.
Tulsa, OK 74104
Attention: Financial Counseling Office