

Roger Mills Memorial Hospital
PO Box 219
Cheyenne, OK 73628
580-497-3336

CHARITY APPLICATION
FINANCIAL STATEMENT

Instructions:

Attach a copy of your most recent tax return.
Attach copies and verification of all sources of income.
Attach copy of denial from Oklahoma Health Care Authority Application

PATIENT INFORMATION

DATE _____ HOME PHONE _____ CELL PHONE _____
NAME _____ SOCIAL SECURITY # _____
MAILING ADDRESS _____
CITY _____ STATE _____ ZIP _____
SEX M F AGE _____ BIRTHDATE _____
 SINGLE MARRIED WIDOWED SEPARATED DIVORCED

RESPONSIBLE PARTY

RESPONSIBLE PARTY NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____ PHONE # _____

RESPONSIBLE PARTY EMPLOYER

EMPLOYER _____ OCCUPATION _____
EMPLOYERS ADDRESS _____
CITY _____ STATE _____ ZIP _____
EMPLOYERS PHONE # _____

ACCOUNT BALANCE: _____ **# OF PEOPLE IN HOUSEHOLD** _____

Source of Income:

Adjusted Gross Income: _____ per year

Social Security: _____ per month

Child Support: _____ per month

Unemployment: _____ per month

Interest Income: _____ per year

Other Income: _____

Other Assets:

Checking Account: _____ Bank Name: _____

Savings Account: _____ Bank Name: _____

Cash: _____ Certificates of Deposit: _____

Stocks/Bonds: _____

Is there any additional information regarding your financial status that you would like to add to this application?

I/we certify that the information provided herein is true and accurate and give consent to Roger Mills Memorial Hospital to verify any information presented in this Financial Statement.

Signature

Date

Relationship

Signature

Date

Relationship

For Hospital Personnel Only Do Not Complete This Page

This application was received on _____

Received by: _____

Approved: _____ Denied: _____

Signature of CEO

Date

Patient Notified in writing on: _____

Date