Okeene Municipal Hospital
Medical/Financial Assistance Application

Patient_____ **Please complete and return with proof of eligibility and/or current tax return or pay stub**

Account # _____ Balance _____ Payment Request_____

_____

Responsible Party: Last Name First Middle Birthday Social Security #

_____

Street Address City State Zip # or Yrs Phone Own Home/Renting

_____

Previous Address City State Zip # of Yrs Phone # Dependents, Include self

Eligibility Determination
[ ] Check here if you are eligible for Supplemental Nutrition Assistance Program or free school lunches (allows you to receive a discount of 80%)
[ ] Check here if you are eligible for WIC or reduced school lunches (allows a discount of 50%)

You could be eligible for 100% discount by providing proof of income. Total family income will be considered for us to make the determination of your discount.

Present Employer_____ Address_____

Phone_____ # of Yrs_____ Salary_____

Other Income_____ Source of other Income_____

Complete below if spouse or co-applicant is employed and include salary information.

Present Employer_____ Address_____

Phone_____ # of Yrs_____ Salary_____

I/We authorize and instruct any person or consumer reporting agency to complete and furnish any information that such person or agencies may have or obtain in response to such credit inquires and agree that such information along with this application shall remain your property.

_____ _____ _____ _____
Applicants Signature Date Co-applicants Signature Date

Exhibit 1