Dear Patient:

Attached you will find the INTEGRIS Health Financial Assistance Program Application. Completion of the form will enable us to consider the need for financial assistance for your medical bill(s). Applications must be resubmitted every six months and must include total household income and total number of persons residing in the household.

To protect your right to privacy, all documents received will be treated as confidential information and except for verification purposes, will NOT be shared with anyone outside of INTEGRIS Health.

Please complete each item on the form. If you need additional space for any explanations, please utilize the back of the application. A credit report may be obtained to verify information provided. **Photographed documents will not be accepted.** All documentation provided shall become the property of INTEGRIS Health and cannot be returned to you.

Copies of all items listed below that are applicable to you must be provided so that a determination can be made for assistance. **Self-prepared taxes using a tax preparation software are not accepted.**

- ☐ Entire copy of the Previous Year Tax Transcript. (*Do not include W-2 forms or pay stubs).*
  - (Go to www.irs.gov or call 1-800-908-9946 to obtain your Official IRS Transcript).
- ☐ Social Security Award Letter. *(Include proof of spouse's income, if applicable).*
- ☐ Physician Disability Statement listing a permanent disability with documentation.
- ☐ Self Employed: Copy of most recent filed personal federal income tax return and a current profit and loss statement, including all schedules that apply.
- ☐ Non-Filers: Provide IRS Verification of Non-Filing letter.
- ☐ Any other documentation, as requested, to process your application.

It is important that you complete this application upon receipt and return it within 15 days. The application will be reviewed within **30** days of receipt and you will be notified via letter of a decision made within **60** days.

If you have any difficulty completing this application or have any questions, please contact our office by phone at (855) 409-5458 or by email at INTEGRISHealthFinancialAssistance@integrisok.com. Office hours are Monday-Friday 8:00am-5:00pm. Your cooperation is appreciated.

Respectfully,

INTEGRIS Health Business Office

INTEGRIS HEALTH

Facilities: _____
Acct(s): _____
Guarantor#: _____

Application for Financial Assistance

Patient Name: Last_____ **First:**_____

Patient Date of Birth: _____ **Social Security #:** _____

Address: _____City_____State_____Zip_____

Guarantor/Spouse Name_____

Guarantor Date of Birth: _____**Guarantor Social Security #**_____

Marital Status: Married_____ Single_____ Divorced_____ Widowed_____

Do you have minor children (under 18)?	Yes_____	No_____
Do they live with you?	Yes_____	No_____
Are they your birth/legally adopted children?	Yes_____	No_____

Name of Employer

_____
Phone #_____
Address_____
Occupation_____

Name of Spouse's Employer

_____
Phone #_____
Address_____
Occupation_____

Income (Monthly Amount)	**Gross** (Before Taxes)	**Family Members** (First, middle and last name)
Patient	$_____	Child _____Age_____
Spouse	$_____	Child _____Age_____
Dependents	$_____	Child _____Age_____
Public Assistance	$_____	Child _____Age_____
Social Security	$_____	Child _____Age _____
Unemployment	$_____	Child _____Age _____
TOTAL INCOME	$_____	Child: _____ Age _____

Please provide any other information you feel would be helpful to us in determining your eligibility for assistance in paying your hospital bill(s).

_____
_____
_____

I understand INTEGRIS Health may verify the financial information contained in this application in connection with the evaluation of this application, and hereby authorize to contact my employer to certify the information provided and to request from the credit report agencies. I am aware this information will be used to determine my eligibility for financial assistance and falsifications. The information in this application is correct to the best of my knowledge. ***This application must be completed to determine eligibility. Incomplete applications may be delayed and/or declined.*** *I further understand any reimbursement of medical expenses I receive relating to this hospitalization must be sent to INTEGRIS.*

_____ _____
Signature of person making request Date

_____ _____
Signature of person making request, if not patient Relationship