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_____

_____

Name Last First Middle Birthday Social Security #

_____

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

_____

Previous Address City State Zip # of Yrs Phone Number of Dependents

Present Employer_____ Address_____

Phone_____ # of Yrs_____ Salary_____

Other Income_____ Source of other Income_____

Eligibility Determination
[ ] Check here if you are eligible for Food Stamps 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 completing the income and expense section below. If you do not qualify for food stamps, WIC or free and reduced lunches complete the income and expense section for us to make the determination.

Income/Assets		**Expense/Liabilities**		
Description	**Cash/Market Value**	**Item-Name of creditor**	**Monthly Payment**	**Present Balance**
Checking-Savings		House		
Stocks-Bonds		Automobiles		
Value of Life Ins.				
Real Estate Owned		Utilities		
Investment in own		Retail Stores		
Business		Groceries		
Automobiles		Phone		
Other Assets		Other Debts		
Total Assets		**Total Liabilities**		

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