Cleveland Area Hospital
Financial Assistance Application
and Instructions

Cleveland Area Hospital ("CAH") offers financial assistance to individuals who qualify. This Financial Assistance Application ("Application") is used in order to determine the level of financial assistance an individual may receive, based on the individual's financial information.

Depending upon your financial situation, you could qualify for a 0% to 100% discount on your hospital charges. If you are eligible, the Application will remain on file and in force for 6 months. Beyond 6 months, a new Application with updated information will be required for evaluation in order for your Application to be considered for additional discounts on hospital care.

The determination of eligibility for financial assistance is based on household/family information. **A family is defined as 2 or more people living together who are related by birth, marriage, or adoption. A family also includes 2 people who live together and who share a common child or children.**

In order to make a timely determination of your eligibility for financial assistance, it is important for you to submit an application within 30 days and to include the following supporting documents along with your Application:

Completed and signed Application Form;
Two most recent pay stubs for every family member;
Prior two years' tax returns for every family member;
Previous two month's bank statements for every family member;

If the above documents are not included with your Application, please explain why in the "Additional Information" section on page 4 of this Application form. Otherwise, a financial counselor from CAH will contact you to inform you of the documents needed to complete your application.

If you have questions about the Application process, or need assistance with completing the Application, please contact an Admissions/Financial Counseling Manager, at (918)358-2501, extension 167.

Please return this Application along with the documents listed above to:

Cleveland Area Hospital Authority
Attention: Financial Counseling Manager
1401 W. Pawnee
Cleveland, OK 74020

Financial Assistance Application Form

Applicant Name:____Date:__________________

Patient Name (if different from Applicant): ____

Circle one: Single Married Widowed Divorced

Name of other Adult in the Household:---
____

Other Adult's relationship to Applicant: -
____

Current Address :____

Applicant's Date of Birth: ___________________ Social Security Number:________________

Phone:_______________________ Age:______________ Gender:___________

Closest Relative Not Currently Living With Applicant:

Name: ________________________ Relationship to Applicant: __________________
Address: ________________________
____
Phone: ________________________

1. How many people live in the same household (see page 1 for a definition of "family")

    a. Number of Adults: _______________
    b. Number of Children: _______________
    c. Ages of Children: _______________

2. Please provide your sources of income in the space provided below:

Source	Monthly Income
______________________________	_____________
______________________________	_____________
______________________________	_____________
______________________________	_____________
Total Gross Monthly Income	_____________

3. Do you have any assets (things of value, such as accounts, cars, other vehicles, stocks, bonds, etc.)? If yes, please list them below:

Assets	Value
______________________________	_____________
______________________________	_____________
______________________________	_____________
______________________________	_____________
Total Assets	_____________

4. What are your monthly liabilities (debts such as bank loans, car loans, credit cards, doctor bills, etc)?

Liability/Debt	Total Owed	Monthly Payment
______________________________	___________________	_____________
______________________________	___________________	_____________
______________________________	___________________	_____________
______________________________	___________________	_____________
______________________________	___________________	_____________
Total Liabilities	___________________	_____________

5. What are your monthly expenses?

	Monthly Payment
Rent or House Payment	___________________
Groceries	___________________
Car Insurance	___________________
Home Insurance	___________________
Water	___________________
Electric	___________________
Gas	___________________
Phone/Cell Phone	___________________
Cable	___________________
Gasoline	___________________
Other	___________________
Total Monthly Expenses	___________________

6. Do you qualify for food stamps? _________________
7. Do your children qualify for reduced school lunches? _________________
8. How long have you lived at your current address? ___________________
9. How long have you been with your current employer? __________________
10. Have you ever filed for bankruptcy? ___________ If yes, when?_____________
11. How did you hear about CAH's Financial Assistance Program? ____________ ____

Additional Information:

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Everything in this Application and the accompanying documents are true and correct to the best of my knowledge.

Signature: ________________________________ Date:__________________________

Printed Name:_____________________________

Note: Free copies of the full-text Financial Assistance Policy, as well as, a Plain-Language Summary of the Financial Assistance Policy, are available:

- in person at the hospital admissions desk;
- online at http://www.clevelandareahospital.com/docs/Charity_Care_Policy_and_Procedure.board.pdf; &
- by mail (please contact an Admissions/Financial Counseling Manager, at (918)358-2501, extension 167 to request a copy).