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

We understand your desire for privacy. Accordingly, except for verification purposes, the information included in your application will be treated as confidential information. It will NOT be shared with anyone outside of OCOM.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application. A credit report may be obtained to verify information given on this application. ***Photographed documents*** **will not be accepted. All documentation provided shall become the property of OCOM 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 are not acceptable.

1. **Entire copy of the Previous Year Tax Transcript if self-prepared.**
   (For your Official IRS - Transcript -Call 1-800-908-9946).
   (This does not include W-2 forms or pay stubs)
2. **Entire copy of the Previous Year Tax Transcript, Social Security Statement (SSA-1099), and Social Security Award Letter.** ***(Include spouse's income, if applicable).***
3. **Entire copy of the Previous Year Tax Transcript with Physician Disability Statement listing a permanent disability with documentation.**
4. **Any other documentation, as requested, to process your application.**

(If you no longer file taxes – you must provide the IRS Non-Filing document for the requirements listed above.)

***If-self-employed**, please provide a copy of your most recent filed personal income tax return and a current profit and loss statement, including all schedules that apply.*

It is very 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 of a decision made within 60 days.** If you have any difficulty completing this application or have any questions, please contact our office at (405) 602-6500. *Office hours Monday-Friday 8:00am-5:00pm or submit to* OCOM Business Office located at 8100 S. Walker Ave, Oklahoma City, OK. 73139. Mailing address is PO Box 890609, Oklahoma City, OK 73189
Your cooperation is appreciated.

Respectfully,
OCOM Business Office

Revised 6.20.23

Facility: ____________
Acct#: ______________
Guar #: _____________

Application for Financial Assistance

Patient Name Last_________________________________**First:**____________________________

Patient Date of Birth: _______________ **Social Security #:** _________________________________

Address: _____________________________**City**____________________**State**______**Zip**________

Guarantor/Spouse Name___________________ **Patient Phone #** ____________________________

Date of Birth: ______________________ **Social Security #:** _________________________________

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**	**Net**
Patient	$_________	$__________
Spouse	$_________	$__________
Dependents	$_________	$__________
Public Assistance	$_________	$__________
Social Security	$_________	$__________
Unemployment	$_________	$__________
TOTAL	$_________	$__________

Family Members

Child _______________Age__________
Child _______________Age__________
Child _______________Age__________
Child _______________Age__________
Child _______________Age__________
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 OCOM 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 charity assistance and falsifications. The information in this application is correct to the best of my knowledge.*

This application must be completed to process, if it is not it may be delayed and/or declined.

I further understand any reimbursement of medical expenses I receive relating to this hospitalization must be sent to ***OCOM****.*

____ ____________________
Signature of person making request Date

____ ____________________
Signature of person making request, if not patient Relationship

Revised 6. 20.23