HPI
COMMUNITY
HOSPITAL
INTEGRIS Network

Dear Patient:

Attached you will find the Community Hospital, LLC ("Community Hospital") Charity Care Program Application. Completion of the application will allow us to determine your need for financial assistance for your medical bill(s).

We understand your desire for privacy. 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 Community Hospital, except as authorized below.

Please complete each item on the application. If you need additional space for any explanations, please utilize the back of the application or a separate sheet of paper. A credit report may be obtained to verify information given on this application. **All documentation you provide shall become the property of Community Hospital 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.

1. **Entire copy of previous year's* Tax Transcript (FOR OFFICIAL TRANSCRIPT FROM THE I.R.S. CALL 1-800-908-9946 or visit their website at IRS.gov) or complete Tax Return. (*This does not include W-2 forms or pay stubs)***
2. **Entire copy of previous year's* Tax Transcript with current years Social Security Award Letter (including spouse's income if applicable)**
3. **Entire copy of previous year's* Tax Transcript with Physician Disability Statement listing a permanent disability and documentation.**

***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. If you fail to provide the requested information your application will be delayed or denied. **The completed application will be reviewed within 30 days of receipt and you will be notified of decision made within 60 days.** Copies of the Financial Assistance Policy and application form are available at www.communityhospitalokc.com and the Community Hospital Customer Service center, **14024 Quail Pointe Drive, Oklahoma City, OK 73134** within Community Hospital. Free copies of the Financial Assistance Policy and application also can be obtained by mail by calling the Customer Service department at 405-419-8444. Additional information about the Financial Assistance Policy is also available upon request in any admissions area and at Customer Service, **14024 Quail Pointe Drive, Oklahoma City, OK 73134 or by telephone at 405-419-8444.**

Yours truly,

Community Hospital
Customer Service Department

ADM-36	Ver# 3
Rev: 3/18/2020	Edited to "Previous year's tax transcript"

HPI COMMUNITY HOSPITAL
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Application for Charity Assistance

FACILITY: _____
Account #:_____
Guarantor #: _____

Patient Name: Last, _____First_____Date of Birth_____

Address: _____City_____State_____Zip_____

Guarantor's Name: _____

Social Security #:_____

Married_____ Single_____ Divorced_____ Separated_____ 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**	**Family Members**
Patient	$_____	$_____	Child:_____Age:_____
Spouse	$_____	$_____	Child:_____Age:_____
Dependents	$_____	$_____	Child:_____Age:_____
Public Assistance	$_____	$_____	Child:_____Age:_____
Food Stamps	$_____	$_____	Child:_____Age:_____
Social Security	$_____	$_____	
Unemployment	$_____	$_____	
TOTAL	$_____	$_____	

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

I understand Community Hospital may verify the financial information contained in this application in connection with the evaluation of this application, and hereby authorize Community Hospital to share my information as necessary to consider my financial assistance request, including contacting my employer to certify the information provided and to request a report from credit report agencies. I am aware this information will be used to determine my eligibility for charity assistance. The information in this application is true and correct to the best of my knowledge. I understand that any incorrect, incomplete or false statements could result in rejection of my application for financial assistance. ***I agree to notify Community Hospital of any changes that could affect my eligibility for financial assistance. This application must be completed to process, if it is not it may be returned to the patient for completion.*** *I further understand any reimbursement of medical expenses I receive relating to this hospitalization must be sent to Community Hospital.*

_____ _____
Signature of person making request Date

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

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