bethany children's
HEALTH CENTER

Financial Assistance Application

We understand medical expenses are often unplanned. In the event of financial hardship, Bethany Children's Health Center will help our patients explore available resources to resolve their medical bills.

Assistance may be available based on the financial condition of our patients' families. This Financial Assistance Application is used to determine eligibility for Bethany Children's Health Center Financial Assistance Program. If approved, this program covers medically necessary services provided by Bethany Children's facilities. It does not apply to physician bills or other fees a patient may incur.

To be considered for financial assistance under our Program, the patient's guardian must provide the information and documentation requested in the Financial Assistance Application. Patients must apply for other existing financial resources that they may qualify for to pay for their healthcare expenses, such as Medicaid.

Please complete the attached application form and return it to the address below along with the supporting documentation:

- Copy of denial of eligibility from Oklahoma Medicaid
- Copy of valid photo ID (Driver's License, State Identification, Military ID, etc.)

COPY OF ONE OF THE FOLLOWING:

- Copy of last 2 year's tax return (all schedules and W2 forms)
- Copy of most recent pay stubs or proof of income (3 months)
- Copy of most recent bank statements (3 months)

Once the complete application is received, a determination will be made and a written response will be sent to the applicant within 30 business days of receipt.

Questions and Assistance in Completion of Financial Assistance Application Form

For further questions or assistance in completion of the assistance application, please call our Business Office (405) 789W 6711 ext.1202. You may also request a summary or complete copy of our Financial Assistance Policy from any Business Office employee or by calling or requesting the policy in writing to: Financial Assistance Processor – Bethany Children's Health Center, 6800 NW 39th Expressway, Bethany, OK, 73008.

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Guarantor Information			
Last Name	First Name	MI	Marital Status
			Single, Married, Divorced or Widowed
Home Address	City, State, Zip	Phone Number	
Employer	Occupation	Length of Employment	

Spouse/ Co-Applicant Information			
Last Name	First Name	MI	Marital Status
			Single, Married, Divorced or Widowed
Home Address	City, State, Zip	Phone Number	
Employer	Occupation	Length of Employment	

Please list all household members *including yourself* & complete information for each				
Full Name	**Social Security Number**	**Date of Birth**	**Relationship to Guarantor**	**School Attending**

Please provide gross income details (prior to deductions) for head of household, spouse and dependents over age 18 and attach supporting documentation.					
Source of Income	**Patient**	**Spouse**	**Other**	**Pay Periods**	**Yearly Total**
Self-Employment				Weekly Bi-Weekly Monthly	
Investment Property				Weekly Bi-Weekly Monthly	
Social Security/ Disability				Weekly Bi-Weekly Monthly	
Pension				Weekly Bi-Weekly Monthly	
Unemployment				Weekly Bi-Weekly Monthly	
Child Support/ Alimony				Weekly Bi-Weekly Monthly	
Workers Compensation				Weekly Bi-Weekly Monthly	
VA Benefits				Weekly Bi-Weekly Monthly	
Other				Weekly Bi-Weekly Monthly	

Please explain why you are requesting financial assistance and provide documentation, if possible (e.g. loss of job, death in the family, divorce, extraordinary medical bills).

Please sign and date below, as application must be signed and dated by all applicable parties in order to complete processing.

I represent that the information provided is true and accurate to the best of my knowledge. I, as payor and signer of this form; certify to the social security number provided to be my legally assigned, individual social security number.

Signature of Patient/Guarantor **Social Security Number** **Date**

I represent that the information provided is true and accurate to the best of my knowledge. I, as payor and signer of this form; certify to the social security number provided to be my legally assigned, individual social security number.

Signature of Spouse/Co-Applicant **Social Security Number** **Date**