Date: ___________ Account #:__________________

Name: ____

Address:____

City/State/Zip: ____

PLEASE FURNISH THE FOLLOWING APPLICABLE ITEMS LISTED BELOW. REQUESTS RECEIVED WITHOUT THE NECESSARY DOCUMENTATION CANNOT BE CONSIDERED AND WILL BE DENIED AUTOMATICALLY. RETURN COMPLETED APPLICATION AND ALL DOCUMENTATION WITHIN 10 WORKING DAYS.

- Financial Application completed in full ***and returned within 10 working days***
- Copy of DHS letter if applicable
- Copy of most recent Social Security Letter of Eligibility if applicable
- Copy of your most recent Federal tax return
- Copy or your two most recent pay stubs if employed
- Copies of last two (2) months checking account statements and most recent savings account statements
- For students, copy of financial aid award letter
- **SIGN THE LAST PAGE OF THE APPLICATION**

Other ____

Thank you,

Patient Accounting Department

For Questions:
970-385-2373

Please mail completed application to the billing office:
Animas Surgical Hospital
236 N.W. 62nd Street
Oklahoma City, OK 73118-7422

Or you can fax to:
405-841-9319

FINANCIAL APPLICATION FORM

PATIENT: ________________________ ACCOUNT NUMBER: ________________

Was this an injury or accident? If so, was it work or motor vehicle related? Please give a brief description of how the injury occurred.

____

____

ALL HOUSEHOLD MEMBERS

NAME	RELATIONSHIP	SS NUMBER	OCCUPATION

GROSS INCOME OF ALL HOUSEHOLD MEMBERS

NAME	SOURCE	MONTHLY INCOME

If an adult in the home is not working, please tell us why, for how long, and the estimated time frame to return to work.

____

____

____

BANK ACCOUNTS

TYPE	NAME OF BANK	BALANCE
____________________	____________________________	___________________
____________________	____________________________	___________________

PROPERTY

DESCRIPTION	VALUE	AMOUNT OWED
CAR: _________________________	_____________	___________________
CAR: _________________________	_____________	___________________
HOUSE: ______________________	_____________	____________________
PROPERTIES: _________________	_____________	____________________

RECREATIONAL EQUIPMENT, (boats, RV's, motorcycles, etc):

_____________________________	_____________	___________________
_____________________________	_____________	___________________
_____________________________	_____________	___________________

MONTHLY PAYMENTS

RENT/MORTGAGE: _________________ MORTGAGE BALANCE: ______________

FOOD: ____________________________

AUTO EXPENSE: ___________________

UTILITIES: _________________________

OTHER: ___________________________

MONTHLY PAYMENTS CONTINUED

MEDICAL EXPENSES	BALANCE	MONTHLY PAYMENT

1. **Do you have health insurance? Yes/No**
2. **If not, does your employer offer health insurance? Yes / No**
3. **Have you applied for coverage with your state, or national healthcare exchange (ObamaCare) if you are uninsured? Yes / No**

CREDIT CARD	PAYMENT	BALANCE

Explanation of why assistance is needed (include separate sheet of paper if needed):

____

____

____

____

I confirm this information to be true and accurate. I understand that Animas Surgical Hospital may verify the financial information contained in this application. I hereby authorize Animas Surgical Hospital to request a credit report if needed. I am aware that this information will be used to determine my eligibility for charity assistance.

________________________________ ________________________

Patient or Guarantor Signature Date