Cleveland Area Hospital
918-358-2501
1401 WEST PAWNEE STREET, CLEVELAND, OK
CLEVELANDAREAHOSPITAL.COM

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 Financial Counseling at 918-358-2501.

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

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

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: https://www.clevelandareahospital.com/policies-and-practices
- By mail (please contact Financial Counseling at **918-358-2501**)

Financial Assistance Application Form

Patient Information

(Please print. All fields must be completed. Indicate N/A if not applicable on any individual line in the application.)

Date: _____ Account Number: _____

First & Last Name: _____

Birth Date: _____ Marital Status: _____ Phone Number: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number: _____

Employer: _____ Employment Status: _____

Number of Hours Worked per Week: _____ Employer Phone Number: _____

Responsible Party's Information / Legal Guardian's Information

(If patient above is same as responsible party, leave this section blank.)

First & Last Name: _____

Birth Date: _____ Marital Status: _____ Phone Number: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number (optional): _____

Employer: _____ Employment Status: _____

Number of Hours Worked per Week: _____ Employer Phone Number: _____

Responsible Party Spouse Information

(If patient is same as responsible party, fill in spouse information for patient.)

First & Last Name: _____

Birth Date: _____ Marital Status: _____ Phone Number: _____

Mailing Address: _____ City: _____ State: _____ ZIP: _____

Social Security Number (optional): _____

Employer: _____ Employment Status: _____

Number of Hours Worked per Week: _____ Employer Phone Number: _____

Dependents of Responsible Party

(If patient is same as responsible party, fill in dependent information for patient.)

Name: _____ Birth Date: _____ Relationship to Responsible Party: _____

Name: _____ Birth Date: _____ Relationship to Responsible Party: _____

Name: _____ Birth Date: _____ Relationship to Responsible Party: _____

Name: _____ Birth Date: _____ Relationship to Responsible Party: _____

Number of Adults and Children Living in Household: _____

Monthly Income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant Earned Income: _____

Applicant Spouse Income: _____

Social Security Benefits: _____

Pension/ Retirement Income: _____

Disability Income: _____

Unemployment Compensation: _____

Worker's Compensation: _____

Applicant Earned Income: _____

Child Support Received: _____

Alimony Received: _____

Rental Property Income: _____

Food Stamps: _____

Trust Fund Distribution Received: _____

Other Income: _____

Other Income: _____

Total Gross Monthly Income: _____

Monthly Living Expenses:

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Mortgage/ Rent: _____

Utilities: _____

Phone (landline): _____

Cell Phone: _____

Groceries/ Food: _____

Cable/ Internet/ Satellite TV: _____

Car Payment: _____

Child Care: _____

Child Support/ Alimony: _____

Credit Cards: _____

Doctor/ Hospital Bills: _____

Car/ Auto Insurance: _____

Home/ Property Insurance: _____

Medical/ Health Insurance: _____

Life Insurance: _____

Total Monthly Expenses: _____

Assets

Cash/ Savings/ Checking Accounts: _____

Stocks/ Bonds/ Investments/ CD(s): _____

Other Real Estate/ Secondary Res.: _____

Boat/ RV/ Motorcycle/ Rec. Vehicle: _____

Collector/ Non-Essential Automobiles: _____

Other Assets: _____

Additional Information or Comments:

_____

_____

_____

_____

_____

I hereby certify that the above information is true and complete to the best of my knowledge. I hereby authorize the hospital to obtain information from external credit reporting agencies if the hospital deems necessary.

Applicant Signature: _____ **Date:** _____