

Wagoner Community Hospital
1200 West Cherokee
Wagoner, Oklahoma 74467
918-485-5514

Questionnaire

Date: _____ Patient: _____

Account #: _____ Balance on Account: _____

Home Telephone Number: _____

You have requested assistance with your hospital charges through the Financial Assistance Program (FAP). To determine if you qualify for the program, we ask that you provide us with the information and/or documents listed below.

In order for you to be considered, we must receive this completed application and all requested information within 7 days of receipt of this letter.

Please include:

- Copy of Federal Income Tax return or statement from last year.
- Copy of Checking Account Bank Statement, dated within the last 30 days.
- Copy of most recent paycheck stub, showing year-to-date earnings.
- Completed FAP application (attached).
- Copy of Rent Receipt/Mortgage payment book.
- Copy of Insurance Billing statement or receipt.
- Copy of Utility Bills
- Copy of Medical Bills
- Documentation of any other liabilities.

Please answer the following questions:

1. Are you eligible for Title 19 assistance? _____
(Write a full explanation on back of this sheet.)

2. Are you eligible for Indian Agency assistance? _____
If yes, give name of agency here: _____

3. Was your hospitalization the result of a Motor Vehicle Accident (MVA)? _____
If yes, give name and phone number of auto insurance company:

4. Were you a Crime Victim? _____
If yes, please give details on the back of this sheet.

5. Are you covered by Medicare? _____ If yes, Medicare #: _____

6. Do you have Medical Insurance coverage? _____
If yes, please give name, address, and phone number of your insurance company:

7. Do you own real estate/property? _____
If yes:
Location of property: _____

Value of property: _____

The preceding information will be reviewed to determine if you qualify for assistance through the Financial Assistance Program. Screening could include requesting a Credit Report to determine eligibility.

Please remember to give a phone number where you can be reached in case of further need of information.

Financial Assistance Program Counselor
918-485-1306

Financial Assistance Program (FAP) Application

Patient Name: _____ Account # _____

1. How many in the family? Adults _____ Children _____

2. Source of Income: Monthly Amount:

Gross Wages.....	_____
Self-Employment.....	_____
Public Assistance.....	_____
Social Security.....	_____
Unemployment/Worker Comp.....	_____
Alimony/Child support.....	_____
Pension/Retirement.....	_____
Other.....	_____

TOTAL INCOME.....Monthly \$ _____ Yearly \$ _____

IF THERE IS NO INCOME, WHERE DOES YOUR SUPPORT COME FROM?.

3. Assets

Cash.....	_____
Stocks/Bonds.....	_____
Autos (List #, Make, Year).....	_____
House/Property.....	_____
Other Assets.....	_____

TOTAL ASSETS....._____

4. Liabilities

Bank Loan.....	_____
Car Loan.....	_____
Credit Union.....	_____
Doctors/Hospitals.....	_____
Other Liabilities.....	_____

TOTAL LIABILITIES....._____

5. Expenses

Rent.....	_____
Food.....	_____
Insurance.....	_____
Utilities.....	_____
Miscellaneous.....	_____

TOTAL PAYMENTS....._____

Responsible Party Signature

Date