Dear Patient:

Attached you will find the INTEGRIS Health Financial Assistance Program Application. Completion of the form will enable us to consider the need for financial assistance for your medical bill(s). Applications must be resubmitted every six months and must include total household income and total number of persons residing in the household.

To protect your right to privacy, all documents received will be treated as confidential information and except for verification purposes, will NOT be shared with anyone outside of INTEGRIS Health.

Please complete each item on the form. If you need additional space for any explanations, please utilize the back of the application. A credit report may be obtained to verify information provided. **Photographed documents will not be accepted.** All documentation provided shall become the property of INTEGRIS Health 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. **Self-prepared taxes using a tax preparation software are not accepted.**

- ☐ Entire copy of the Previous Year Tax Transcript. (*Do not include W-2 forms or pay stubs).*
  - (Go to www.irs.gov or call 1-800-908-9946 to obtain your Official IRS Transcript).
- ☐ Social Security Award Letter. *(Include proof of spouse's income, if applicable).*
- ☐ Physician Disability Statement listing a permanent disability with documentation.
- ☐ Self Employed: Copy of most recent filed personal federal income tax return and a current profit and loss statement, including all schedules that apply.
- ☐ Non-Filers: Provide IRS Verification of Non-Filing letter.
- ☐ Any other documentation, as requested, to process your application.

It is important that you complete this application upon receipt and return it within 15 days. The application will be reviewed within **30** days of receipt and you will be notified via letter of a decision made within **60** days.

If you have any difficulty completing this application or have any questions, please contact our office by phone at (855) 409-5458 or by email at INTEGRISHealthFinancialAssistance@integrisok.com. Office hours are Monday-Friday 8:00am-5:00pm. Your cooperation is appreciated.

Respectfully,

INTEGRIS Health Business Office

INTEGRIS HEALTH

Application for Financial Assistance

PATIENT NAME IN FULL		SEX M ☐ F ☐	AGE	MEDICAL RECORD NUMBER
PATIENT DATE OF BIRTH	ARE YOU A CITIZEN OF THE UNITED STATES Yes ☐ No ☐	HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID) Yes ☐ No ☐		MARITAL STATUS: SINGLE ☐/ MARRIED ☐ DIVORCED ☐/ WIDOWED ☐

RESPONSIBLE PARTY INFORMATION

PATIENT		**SPOUSE or GUARANTOR** (for minor patients)		
NAME		NAME		
ADDRESS		CITY	STATE	ZIP CODE
PHONE NUMBER ( )	CELL PHONE ( )	PHONE NUMBER ( )	CELL PHONE ( )	
SOCIAL SECURITY NUMBER		SOCIAL SECURITY NUMBER		
EMPLOYER		EMPLOYER		
IF UNEMPLOYED, LAST DATE WORKED		IF UNEMPLOYED, LAST DATE WORKED		
DATE LAST CHECK RECEIVED:		DATE LAST CHECK RECEIVED:		

FAMILY INFORMATION

FAMILY MEMBERS LIVING IN THE HOME				
NAME	AGE	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

PATIENT AND FAMILY INCOME

List Monthly Totals

PATIENT $	SPOUSE $	DEPENDENTS $	PUBLIC ASSISTANCE $
SOCIAL SECURITY $	UNEMPLOYMENT $	PENSION/RETIREMENT $	CHECKING/SAVINGS ACCOUNT $
DISABILITY $	STOCKS/BONDS $	DIVIDENDS/INTEREST $	MUTUAL FUNDS/MONEY MARKET FUNDS $
WORKERS COMPENSATION $	SELF EMPLOYMENT - ATTACH SCHEDULE C $		**TOTAL MONTHLY INCOME: $**

I understand that INTEGRIS Health may verify financial information contained in this application in connection with the evaluation of this application, and hereby authorize contact with my employer to certify the information provided and/or request credit report from agencies. I am aware this information will be used to determine my eligilibity for financial assistance and falsifications. The information in this application is correct to the best of my knowledge. ***This application must be completed to determine eligibility. Incomplete applications may be delayed or declined.*** *I further understand any reimbursement of medical expenses I receive related to this application must be sent to INTEGRIS Health.*

Signature of person making request _____ Date _____

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

Revised 2/1/2022