# Ozarks Medical Center

The Right Care, Right Here

Patient Accounts, P.O. Box 1100, West Plains, MO 65775
(417) 257-6701, (888) 257-8389

| | | |
|---|---|---|
| Ozarks Medical Center | Rheumatology Clinic | Orthopedic Clinic |
| West Plains Imaging | Cancer Treatment Center | Pain Management Clinic |
| Internal Medicine Clinic | Heart Care Services | Surgical Specialists Clinic |
| Urology Clinic | Neuroscience Center | Wound Care Clinic |

Please complete this financial statement with signatures of the responsible party(s) and return the application and all information requested below to the address listed above in order for us to begin processing your application for financial assistance and/or payment options. This application is used for the Ozarks Medical Center hospital facility and the Ozarks Medical Center Clinics only. Failure to return the requested information may result in your application being denied.

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|---|---|
| | Complete 20__ Federal Tax Return; for self-employed we also need Complete 20__ Federal Tax Return |
| | Personal Taxes from County |
| | Property Taxes from any County in which you own property |
| | Copies of Bank Checking & Savings Account Statements for the last three months |
| | Verification of current household income: pay stubs, Social Security benefits, etc. |
| | Verification of Child Support – proof of dollar amount received is needed |
| | Letter from a non-family/non-household member stating how long that person has known you and how long you have been unemployed |
| | Verification from Division of Family Services of Medicaid denial |

| Patient Name | Age | Phone Number | Marital Status | Patient Social Security No. |
|---|---|---|---|---|
| | | | S M W D | |

| **Patient Information** | **Person Responsible for Bill** | Relationship | |
|---|---|---|---|
| Address: | Name: | | |
| | Address: | | |
| City: | | | |
| State: | City: | State: | Zip: |
| Zip: | Phone: ( ) | | |
| Phone: ( ) | | | |

| **EMPLOYMENT** | |
|---|---|
| Patient's Employer | Person Responsible Employer |
| | |
| Occupation | Occupation |
| | |
| If Unemployed, Name of Last Employer | If Unemployed, Name of Last Employer |
| | |
| How Long Unemployed | How Long Unemployed |

| LIST BELOW ALL MEMBERS OF HOUSEHOLD (Including Patient) | | |
|---|---|---|
| Name | Age | Relationship to Patient |
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|---|---|---|---|---|---|
| Do you have health insurance coverage available? | Yes | No | Have you Applied For Medicaid? | Yes | No |
| If yes, why not available for this date of service? | | | Date Applied: | | |
| | | | If Denied, Date: | | |
| If no, Please indicate reason for lack of insurance coverage: | | | Reason for Denial: | | |
| Insurance Cost is too High | Other, Please Describe | | Please attach a copy of Medicaid Denial letter. | | |
| Yes / No | | | | | |

| MONTHLY INCOME | | | |
|---|---|---|---|
| | Patient | Spouse | Other |
| Wages (Gross) | | | |
| Social Security | | | |
| Pensions | | | |
| Unemployment/Work Comp | | | |
| Alimony/Child Support | | | |
| Government Assistance | | | |
| Disability Payments | | | |
| Strike Benefits | | | |
| Scholarships/Grants | | | |
| Dividends/Interest | | | |
| Other, List | | | |

| EXPENSES | MONTHLY | BALANCE DUE | ASSETS – VALUE | PATIENT (Joint) |
|---|---|---|---|---|
| Mortgage or Rent Payment | | | Savings | |
| Car Payment | | | Checking | |
| | | | Investments, Stocks, Bonds | |
| Utilities (Gas, Electric, Etc.) | | | Money Market | |
| Cable | | | CD's | |
| Phone | | | Investments, Stocks, Bonds | |
| Food | | | Home (Market Value) | |
| Child Care | | | Car/Motorcycle | |
| Clothing | | | Make/Model | |
| Auto Insurance | | | Year | |
| Homeowners Insurance | | | Car/Motorcycle #2 | |
| Health Insurance | | | Make/Model | |
| Gas/Transportation | | | Year | |
| Recreation | | | Car/Motorcycle #3 | |
| Prescriptions/Medications | | | Make/Model | |

| | | | | |
|---|---|---|---|---|
| Physicians | | | Year | |
| Credit Cards | | | Car/Motorcycle #4 | |
| | | | Make/Model | |
| | | | Year | |
| | | | Boats/ATVs/Other | |
| Other Expenses (Describe) | | | Other Property/Real Estate | |
| | | | IRA, 401k, 403b | |
| | | | | |
| OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION (OR CAN BE ATTACHED): | | | | |

Please briefly describe what situation (medical, financial and/or other) that you (and/or family member) are currently experiencing that leads to your need for financial assistance:

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| I/we certify that the information provided in connection with this financial assistance application and/or payment options is correct and complete. I/we authorize Ozarks Medical Center to request a credit inquiry for verification with the signature and information we have provided. I/we understand that additional documentation may be requested. I/we understand that if it is found that I/we did have insurance or a third party payer that has reimbursed me/us on the charges for which I/we received financial assistance, or any information is found to be false, the financial assistance and/or arrangements may be voided. |
| Patient/Responsible Party Signature: Date: |
| Patient/Responsible Party Signature: Date: |