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

Ozarks Healthcare	Rheumatology Clinic	Orthopedic Clinic
West Plains Imaging	Cancer Treatment Center	Pain Management Clinic
Internal Medicine Clinic	Heart and Lung Center	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 Healthcare hospital facility and the Ozarks Healthcare Specialty Clinics only.

*Failure to return the requested information may result in your application being denied.

	Complete 2020 Federal Tax Return; for self-employed we also need Complete 2019 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
		Self

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 #1	
2nd Car Payment			Checking #2	
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:

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 Healthcare 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: