OAKBEND MEDICAL CENTER

APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for giving us the opportunity to serve your healthcare needs and for expressing interest in our Financial Assistance Program.

Please complete this application and return it *along with all supplemental documentation required* within 15 days to avoid possible denial of your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of OakBend Medical Center except for the purpose of assessing your need for financial assistance.

Please provide the following information completely and accurately. Information is subject to verification. Please attach a list of additional immediate household members if there are more than five (5) members.		
Patient Name (First, MI, Last)	SSN	Total # of household members
Address	Date of Birth	Home/Cell Phone
City/State/ZIP		Work Phone
Guarantor Name	Account #	

Dependents may live outside of your primary household residence if they are claimed on your or your spouse's tax return.

List ALL household member names	Date of Birth	SSN	Relationship to Patient	Insurance
1		- -		Yes / No
2		- -		Yes / No
3		- -		Yes / No
4		- -		Yes / No
5		- -		Yes / No

Monthly Income

Gross Monthly Income (GMI)			
Source:	$		
Source:	$		
Source:	$		
Source:	$		
Source:	$		
Total	$		
Medical Expenses		**Assets**	
Medical/Health Bills:		Bank:	$
Billing Entity:	$	Bank:	$
Billing Entity:	$	Other:	$
Billing Entity:	$	Total	$
Billing Entity:	$		
Billing Entity:	$	**Non-Medical Debts:**	
Billing Entity:	$	Item 1:	$
Billing Entity:	$	Item 2:	$
Total	$	Item 3:	$
		Total	$

I CERTIFY that the information I have provided is a true and accurate representation of my family size and household income. I understand that any misrepresentation of this information will result in denial of financial assistance.
I authorize OakBend to access additional sources of information to verify my qualification for assistance.

Patient/Applicant Signature ______________________________ Date ____________________

Spouse Signature (if co-applicant) ______________________________ Date ____________________

Thank you for your application and for the opportunity you have given us to serve your health care needs. Please return your completed application and all supporting documentation to: Fax Number: 281-341-4827, Email: finassistanceprogram@obmc.org , or U.S. Mail Address to : Attention: Patient Access – Financial Assistance, 1705 Jackson Street, Richmond, TX 77469. Please call 281-633-4074 if you have any questions or need assistance with this application.

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