McAlester Regional Health Center

Charity Care/Financial Assistance Application

Applications for charity care assistance may be completed in the McAlester Regional Health Center Cashier's office or by mail. You will be required to fully complete the application and provide all required information about monthly income, and assets owned. In addition, we ask that you provide a copy of your most recent federal tax return as well as other documents listed on the application.

In evaluating your application, MRHC will consider your income, debts owed, residence demographic, and assets owned. To be considered for charity care, you may not have assets out of proportion with the assistance requested. Charity care is available to legal citizens of McAlester and surrounding communities.

Charity care is given for the hospital facility charges only. Arrangements to pay your Physician, Radiologists, Specialty Clinic, Anesthesia, and all other professional services not provided by the McAlester Regional Health Center are not eligible and would have to be contacted individually for arrangements or assistance if available. This includes any billing from the following: Team Health (ER Physicians), Urgent Care Clinic, Warren Clinic (Saint Francis), Radiology Associates, Blue Sky Anesthesia, Southeastern Medical Laboratory, and MRHC Hospitalists, Southeast Orthopedic, Southeast Urology, and Southeast Family Practice.

Charity applications must be returned within 30 days of the application being picked up or mailed. Failure to return the application in a timely manner will result in a denial. Good faith payments are required monthly during the application process until a final decision has been made regarding your application.
Applications are processed at the end of each calendar month. Patients will be notified by mail once the application is processed and reviewed by the charity care committee.

Please return all forms to:

MRHC

ATTN: PATIENT FINANCIAL SVCS, CHARITY DEPT.

PO Box 1228

McAlester, OK 74502

Or return in person to the cashier's office in admitting.

For questions about your application contact:

Patient Financial Services at

918-421-3875 or email: insurance@mrhcok.com

McAlester Regional HEALTH CENTER

Hospital Representative_____ Application Date _____ Received Date _____

Patients Name _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone Number (home) _____ (Cell) _____

Months at Current Residence _____ Rent or Own (Circle One) Amount_____

Employer/Source of Income _____

Employer Phone Number _____ Months at Job _____

How often are you paid? Monthly Weekly Bi-Weekly (Circle One) Other (Explain) _____

Have you applied for state, federal or county assistance? Yes/No (Circle One) If Yes When? _____

Were you screened for Medicaid or Disability at MRHC? Yes/No (Circle One)

Do you qualify for medical assistance through a Governmental agency or program, an employer sponsored health plan, or any other program from which you could obtain payment assistance? (Such as Tribal, DHS, Medicare, Medicaid, or Health Insurance) Yes/No (Circle One) If Yes Who? _____

Spouse's Name _____

Spouse's Employer/Source of Income _____

Spouse's Employer Phone Number _____ Months at Job _____

How often are they paid? Monthly Weekly Bi-Weekly (Circle One) Other (Explain) _____

List all members living in the household as well as their earnings received. Earnings include but are not limited to: unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, paycheck from employment, and other miscellaneous sources.

Non-cash benefits (such as food stamps and housing subsidies) do not count.

Determined on a before-tax basis and excludes capital gains or losses, for the previous 12 month period.

Do not list any non-relatives, such as housemates.

List all household members and income (List the Applicant First)

Name	Relationship	Date of Birth	Social Security #	Monthly Income
	Self			

Total Yearly Household Income $ _____

Assets:

Do you have a bank account? Yes/No (Circle One)

Name of Financial Institution(s) _____

Checking Account Number(s) _____

Checking Account Balance(s) _____

Savings Account(s) _____

Savings Account Balance(s) _____

List any property you own including land and or rent houses

Address	County/State	Type	Market Value	Amount Owed

Credit Cards

Credit Card Type (Visa/ MasterCard/Discover)	Credit Card Limit	Credit Card Balance	Monthly Payment

Vehicles

Make/Model	Value	Amount Owed	Monthly Payment

The following documentation must be received in order for your application to be processed. Failure to provide proper documentation will result in an automatic denial of eligibility for charity care.

- DHS eligibility letter showing dates of coverage.
- Social Security Eligibility Letter/ Awards Letter
- For full time students, a copy of their Financial Aid Award Letter (student loans do not count as income)
- A signed copy of the most current year's federal income tax return including 1040's, all schedules, and copies of the most recent W-2's for each household wage earner.
- Verifiable income statements such as pay stubs, for the last two months. Other income includes financial assistance from parents or other relatives, child support, alimony, interest income, tips, unemployment, etc. Self-employed patients will be required to produce a quarterly tax return if they contend that their current income differs from their prior years' income.
- Patients with no verifiable income must provide a written statement from the person who provides them with food and shelter with a contact number for verification.
- Proof of Food Stamps
- Proof of Medicaid eligibility for any household member
- A bank statement showing the last 30 days of bank transactions and a running total of account balances.

If you do not qualify for, or qualify for a partial reduction for MRHC's Financial Assistance Program, what is your proposed monthly payment? _____

McAlester Regional Health Center is authorized to check my credit history.

I certify that the above information is correct, and I hereby authorize the McAlester Regional Health Center to verify all of the above information. I authorize third party release to McAlester Regional Health Center any information required to verify and authenticate this application.

I understand that to process this application additional information may be needed and it must be provided when requested. I understand that failure to do so will result in an automatic denial. Failure to provide all documentation requested will also result in an automatic denial.

The application must be received within 30 days of the day it was picked up or mailed from the hospital. Failure to return the application on time will result in a denial.

Applicants Signature _____ Date _____

PATIENTS NAME: _____

THIS PAGE TO BE COMPLETED BY MRHC REPRESENTATIVE

Account Numbers	Date of Service	Account Balance	Self-Pay Adjustment	Reduction Amount	Remaining Balance

2025 FEDERAL POVERTY GUIDELINES FOR CHARITY CARE

QUALIFING AMOUNT	Qualifying percentage is up to the FPG% below:	100%	95%	90%	75%	70%
FPG %	100%	133%	150%	200%	250%	300%
NUMBER IN HOUSEHOLD	FOR FAMILIES/HOUSEHOLDS WITH MORE THAN 8 PERSONS ADD $5,500 FOR EACH ADDITIONAL PERSON.					

1	$15,650	$20,815	$23,475	$31,300	$39,125	$46,950
2	$21,150	$28,130	$31,725	$42,300	$52,875	$63,450
3	$26,650	$35,445	$39,975	$53,300	$66,625	$79,950
4	$32,150	$42,760	$48,225	$64,300	$80,375	$96,450
5	$37,650	$50,075	$56,475	$75,300	$94,125	$112,950
6	$43,150	$57,390	$64,725	$86,300	$107,875	$129,450
7	$48,650	$64,705	$72,975	$97,300	$121,625	$145,950
8	$54,150	$72,020	$81,225	$108,300	$135,375	$162,450

*Patients with income over 300% of the poverty level are over income for charity
Total Household income_____ Number in household _____

Approved %: _____Total amount approved: $_____Total amount denied: $_____

Approved By: _____ Date: _____
(Financial Counselor)

Approved By: _____ Date: _____
(Director Patient Financial Services)

Approved By: _____ Date: _____
(CFO $5000 to $10,000)

Approved By: _____Date: _____
(CEO over $10,000)