Tulsa
Rehabilitation Hospital

We are presently reviewing your account. To review this account for financial circumstances, we are requesting the following:

a) a completed financial assessment form
b) a copy of last year's tax return or your most recent bank statement
c) a copy of your most recent pay stub or unemployment check
d) proof of any state or federal assistance such as food

These items are necessary to document your financial conditions and for us to process your request for assistance.

Please return the requested items as soon as possible. You may call 918-820-3499 if you have any questions. Thank you for choosing Tulsa Rehabilitation Hospital for your rehabilitation services. You will be contacted if any additional information is needed and also to inform you of the decision made on the above referenced balance.

Mailing Address:
Tulsa Rehabilitation Hospital
7909 South 101st East Avenue, Tulsa OK 74133

Tulsa Rehabilitation Hospital

PATIENT NAME IN FULL	M F	AGE	DATE OF BIRTH

ARE YOU A CITIZEN OF THE UNITED STATES	RESIDENT OF OKLAHOMA	HAVE YOU APPLIED FOR MEDICAL ASSISTANCE (MEDICAID)	IF YES, INDICATE MONTH	YEAR
Yes No	Yes No	Yes No		

ARE YOU OR YOUR SPOUSE SELF-EMPLOYED	DID YOU FILE A FEDERAL TAX RETURN	STATE TAX RETURN	DO YOU HAVE THIRD-PARTY INSURANCE COVERAGE
Yes No	Yes No	Yes No	Yes No

RESPONSIBLE PARTY INFORMATION

APPLICANT		APPLICANT'S SPOUSE		
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 AND PATIENT INFORMATION

FAMILY MEMBERS LIVING IN THE HOME

NAME	DATE OF BIRTH	AGE	RELATIONSHIP	SOCIAL SECURITY NUMBER

FAMILY INCOME (List Amounts of Each)

Patient	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	
Spouse	SALARY / WAGES / TIPS	INTEREST / DIVIDENDS	ALIMONY	SOCIAL SECURITY	PENSION / RETIREMENT
	DISABILITY	UNEMPLOYMENT	WORKERS COMP	SELF EMPLOYMENT - ATTACH SCHEDULE C	

FAMILY RESOURCES

Checking Account(s)		
Savings Account(s)		
IRA / 401K / 430B		
Food Stamps (list amount received)	WIC ☐ No ☐ Yes (Need Qualifying Letter)	LOW INCOME HOUSING ☐ No ☐ Yes (Need Qualifying Letter)

PROPERTY (HOUSE OR PERSONAL PROPERTY OTHER THAN YOUR RESIDENCE) - *DESCRIPTION AND LOCATION*	MARKET VALUE $
IS THIS HOSPITAL SERVICE / PHYSICIAN SERVICE A RESULT OF A PERSONAL INJURY/ACCIDENT CASE FROM WHICH YOU EXPECT TO RECEIVE A SETTLEMENT ☐ Yes ☐ No	IF YES, EXPECTED AMOUNT $

I hereby acknowledge that I have read this document. It has been provided in printed format or explained to me in my native language and was understood. I certify that all information regarding income and assets are true. I understand that the information which I submit concerning my income, assets, liabilities, and family size is subject to verification. I hereby authorize the release of any necessary information from individuals, universities or colleges, businesses, public or private organizations to determine my eligibility. I assign and transfer to Saint Francis Health System all my rights to benefits, monies, and sums payable to me for hospitalization, sickness, or accident liability coverage. I understand that failure to disclose information and/or payments will result in denial of the application.

PATIENT - SIGNATURE	DATE	TIME

PERSON COMPLETING FORM, IF OTHER THAN PATIENT - SIGNATURE	RELATIONSHIP TO PATIENT	DATE	TIME

INTERPRETER / WITNESS - SIGNATURE _____ DATE

Tulsa Rehabilitation Hospital

TIME

PATIENT LABEL

FINANCIAL ASSESSMENT APPLICATION 936-011E front / 12-14

IN01 FINANCIAL ASSESSMENT APP