



Cordell Memorial Hospital
1220 N Glenn L English
Cordell, OK 73632
580-832-3339

FINANCIAL ASSISTANCE SUMMARY

It is the policy of Cordell Memorial Hospital to provide essential services regardless of the patient's ability to pay. Discounts are offered based on family size and annual income. Please complete the following information and return to the front desk along with the requested documents to determine if you or members of your family are eligible for a discount.

The discount will apply to all services received at this facility, but not those services or equipment that are purchased from outside facilities. These include reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist and other such services. This form must be completed every 6 months or if your financial situation changes.

Financial Assistance is available on the following sliding scale. Each applicant's financial need is based on the Federal Poverty Guidelines, which include income and number of family members. Financial need does not consider age, gender, race, social or immigrant status, sexual orientation or religious affiliation.

Federal Poverty Level (View Chart)	At or Below 150%	175%	200%	Above 200%
Financial Assistance	You pay \$0	You pay 50%	You pay 80%	You pay 100%

Applicants will be notified within 30 days of receipt of a **completed** application.

Please attach to this application the following documents:

- **Proof of Income**
 - Tax Return
 - Pay Stubs – last 2 months
- **Last 2 months Bank Statements**
- **Denial from Medicaid**



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FINANCIAL ASSISTANCE APPLICATION

Name of Head of Household:		Place of Employment:		
Street:	City:	State:	Zip:	Phone:

Please list spouse and dependents under the age of 18

Name	DOB	Name	DOB
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	
Dependent		Dependent	



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Annual Household Income and Expenses

<u>Source</u>	<u>Self</u>	<u>Spouse</u>	<u>Other</u>	<u>Total</u>
Gross wages, salaries, tips, etc				
Income from business, self-employment and dependents				
Unemployment compensations, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and miscellaneous sources				
<u>Total</u>				



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<u>Expenses</u>	<u>Amount</u>
Rent/Mortgage	
Medical/Dental Bills	
Utilities	
Other(specify)	
<u>Total</u>	

I certify that the family size and income information shown above is correct.

Name (Print): _____

Signature: _____ Date: _____



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Notice of Availability of Uncompensated Services

Eligibility for free or reduced care cost will be limited to persons whose family income is not more than 200% of the current poverty income guidelines established by the Department of Health and Human Services. Please review the income levels listed below for possible eligibility.

2025 Annual Federal Poverty Guidelines

Size of Family Unit	At or Below 150% FPG	175% of FPG	200% of FPG	Above 200% of FPG
	You Pay \$0	You Pay 50%	You Pay 80%	You Pay 100%
1	0-\$23475	\$23476 - \$27387.50	\$27387.51 - \$31300	\$31301 -
2	0-\$31725	\$31726 - \$37012.50	\$37012.51 - \$42300.	\$42301 -
3	0-\$39975	\$39976 - \$46637.50	\$46637.51 - \$53300	\$53301 -
4	0-\$48225	\$48226 - \$56262.50	\$56262.51 - \$64300	\$64301 -
5	0-\$56475	\$56476 - \$65887.50	\$65887.51- \$75300	\$75301 -
6	0-\$64725	\$64726 - \$75512.50	\$75512.51 - \$86300	\$86301 -
7	0-\$72975	\$72976 - \$85137.50	\$85137.51 - \$97300	\$97301 -
8	0-\$81225	\$81226 - \$94762.50	\$94762.51 - \$108300	\$108301 -
For each additional person, add	\$8250	\$9625	\$11000	\$11000



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DETERMINATION OF FINANCIAL ASSISTANCE – OFFICE USE ONLY

Date: _____

Name: _____

Yearly gross income of household: _____

Poverty Guidelines: _____ Family Size: _____

Approved: _____ Starting Date: _____

Denied: _____

Comments: _____

Percentage approved: _____

Account: _____ Amount: _____

Account: _____ Amount: _____

Account: _____ Amount: _____

Account: _____ Amount: _____

Account: _____ Amount: _____