P.O. Box 1100, West Plains, MO 65775
(417) 257-6701

Ozarks Healthcare Alton	Ozarks Healthcare Mountain Grove
Behavioral Healthcare	Ozarks Healthcare Winona
Ozarks Healthcare Gainesville	Ozarks HealthcareThayer
Ozarks Healthcare Mammoth Spring	Ozzarks Healthcare Women's Healthcare
Ozarks Healthcare Mtn View	Ozarks Healthcare West Plains
Ozarks Healthcare Pediatrics	Ozarks Healthcare Family Care

Ozarks Healthcare is committed to providing excellent health care in a manner that is affordable to all of our patients. To ensure that quality medical care is available to all of our patients, Ozarks Healthcare Rural Health Clinics and Behavioral Health Care has a financial assistance program to help the uninsured and underinsured. You may receive assistance up to 100% of your charges based on your income. Information in the attached form will be used only to determine you eligibility and will be kept in confidence at the Patient Financial Services office in West Plains.

Once you completed application has been received by Patient Financial Services, Patient Financial Services will review your application and a determination letter will be mailed to the address on the application.

If you have questions concerning your application, feel free to contact a financial counselor at (417) 257-6701 or toll free at (888) 257-8389.

Additionally, the Clinic Supervisor at the clinic or I will be glad to assist you in any way.

Sincerely,
Melody Simpson
Director of Patient Financial Services
Ozarks Medical Center
(417) 257-6701 ext. 6028

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It is the policy of Ozarks Healthcare 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 address listed above to determine if you or members of your family are eligible for a discount.

This discount will apply to all services received at the locations mentioned above, but not those services or equipment that are purchased from outside, including reference laboratory testing, drugs, and x-ray interpretation by a consulting radiologist, and other such services. This form must be completed every 12 months or if your financial situation changes.

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

County of residence:

Please list spouse and dependants under age 18

Name	Date of Birth	Name	Date of Birth
Self		Dependant	
Spouse		Dependant	
Dependant		Dependant	

Dependant		Dependant	
Dependant		Dependant	

Annual Household Income

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc.				
Income from business, self-employment, and dependants				
Unemployment compensation, 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 other miscellaneous sources				
Total Income				

NOTE: Copies of tax returns, pay stubs, or other information verifying income may be required before a discount is approved.

I certify that the family size and income information shown above is correct.ave provided.	
Name (Print):	Date:
Signature:	Date: