GODDARD HEALTH CENTER
The UNIVERSITY of OKLAHOMA

Patient Assistance Request Form

The Patient Assistance Fund supports eligible OU students by reducing the financial burden of accessing essential medical and mental health care. The fund provides up to $50 per semester (maximum $100 per academic year**)** to assist with out-of-pocket medical expenses, prescription co-pays**,** and University Counseling Center services.

Eligibility Criteria

- Must be a currently enrolled OU student
- Must not have exceeded the maximum annual assistance amount
- Funding availability at the time of request

Today's Date: _____

Name: _____ Student ID: _____

Phone Number: _____

Amount requested: $_____ for the following (check all that apply)

Pharmacy Services☐ Medical Services☐ Counseling Services☐

Have you received patient assistance through OU Health Services this semester? _____

I certify that I am a currently enrolled OU student and authorize OU Health Services to review my eligibility for assistance from the Patient Assistance Fund. I understand that approval is not guaranteed and is subject to available funds.

Signature of patient: _____ Date: _____

For Department Use Only

If previous assistance was received through OU Health Services, date approved, and amount verified:

_____

Amount Approved for current request: $ _____

Approved by: _____