



**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. The fund is limited to current charges only.

**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: \_\_\_\_\_