CoxHealth Foundation

Application for Patient Assistance

For Office Use: Payment source: Fund/Grant
Approved by:

The funds for assistance are made possible by donors to the CoxHealth Foundation. This program is for financial assistance for medical bills/patient care assistance at CoxHealth only.

☐ **I am applying for assistance with hospital charges.**

1. **Attach some form of proof of income**; examples are: tax return, pay stub, disability or Social Security letter. Please attach a minimum of one form **or** an explanation of why there is no data attached. Not including income information will result in a delay of the review of your application and possible denial of financial assistance.
2. ***If you have no insurance you must first* complete the CoxHealth Financial Assistance Program**. Contact Financial Services at 417-269-0532 or 417-269-3117 for an application. This will assist in providing a DISCOUNT to you on your bills, up to 90%.
3. ***Please establish a* payment plan with CoxHealth Patient Financial Services** for the outstanding balance on your bill shows you are working in good faith to do your part. If your bills are in collections at the time of review, you will be denied.

Note: Applications are reviewed monthly and you will be informed by letter if you are approved or denied. It may take several months from the time of application receipt to review based on the volume of applications received.

☐ **I am applying for assistance with non-covered hospital/prescription/equipment/special needs.**

1. ***Attach proof of income to the application and caseworker or physician office letter or form verifying your request. This form/letter must include cost of what is requested and where it will be purchased. .*** Please ask your social worker for assistance with getting the required cost information. No caseworker? Call 269-7068- Cox Health Case Management.

Note: *Applications are reviewed as received.*

Questions? Call 417-269-7150
Monday – Friday from 8:30 AM – 5:00 PM

Send completed application, proof of income, and explanation of need to:

CoxHealth Foundation
3525 S. National, Suite 204
Springfield, MO 65807
Fax: 417-269-9599

www.coxhealthfoundation.com

If required materials are not received the application can be delayed for consideration.

APPLICANT INFORMATION		
Patient Name:		
Date of Birth:	SSN:	Phone:
Email:		
Current Address:		
City:	State:	ZIP:
Spouse's Name:	Guardian Name:	

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Number of Children Living at Home:	Ages of Children:	
Number of Grandchildren Living at Home:	Other Family in the Home:	
EMPLOYMENT/INCOME INFORMATION		
Patient Current Employer:		How long?
Monthly Gross Income:$	Social Security: $	Unemployment: $
Alimony: $	Child Support: $	Other Income: $
Spouse's Employer:	Spouse's Monthly Gross Income: $	
INSURANCE (IF YOU HAVE NO INSURANCE, APPLY TO PATIENT FINANCIAL SERVICES FOR DISCOUNT. CALL 269-8146 FOR ASSISTANCE)		
Is your bill related to an accident: Yes No	Workers Compensation? Yes No	
Medical Insurance: Yes No	Name of Insurance Co:	
Medicaid: Yes No	If no have you applied? Yes No	Date:
Medicare: Yes No	Other (list):	
CARE INFORMATION		
Physician Name(s):		
Date(s) of Service:	ER Inpatient Outpatient Urgent Care Ambulance Other	
FINANCIAL ASSETS		
Name of Bank:		
Amount in Checking: $	Amount in Savings: $	
CD's / Stock's / Bond's: $	Pension: $	
Retirement Funds: $	Investments: $	
REAL ESTATE		
Do You Own Your Home? Yes No	Finance Company:	
Balance Owed: $	Market Value: $	Monthly Payment: $
Do You Own Rental Property? Yes No	If Yes, Monthly Income: $	
Do You Own Acreage? Yes No	If Yes, Monthly Payment: $	
PERSONAL PROPERTY		
Automobile Year:	Make:	Model:
Automobile Year:	Make:	Model:
Truck Year:	Make:	Model:

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Recreational Vehicle Year:	Make:	Model:
Boat Year:	Make:	Model:
Farm Machinery Year:	Make:	Model:
Livestock: Yes No	If Yes, List:	
MONTHLY EXPENSES		
Rent/Mortgage: $	Utilities: $	Propane: $
Food: $	Gasoline: $	Mobile Phone: $
Medical Insurance: $	Auto Insurance: $	Other: $
Child Support: $	Alimony: $	Other: $
Loan (type/finance company):		Amount: $
Loan (type/finance company):		Amount: $
Credit Card:		Amount: $
Credit Card:		Amount: $
OUTSTANDING MEDICAL EXPENSES- IF NOT INSURANCE, APPLY TO PATIENT FINANCIAL SERVICES FOR A MEDICAL DISCOUNT. CALL 269-0523 FOR ASSISTANCE WITH HOSPITAL CHARGES ON YOUR BILLS. THIS DOES NOT APPLY TO PHYSICIAN'S BILLS FOR THE DISCOUNTS OFFERED BY COXHEALTH.		
Physician or provider:		Amount: $
Physician or provider:		Amount: $
Additional medical information:		

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Please tell us why you need help and WHAT you need assistance with or for---meaning what health problem are you having. Use an additional sheet of paper if necessary, or write on the back of this application. **DO NOT LEAVE THIS BLANK**. This must be completed for your request to be considered.

If you receive assistance, can we tell your story to encourage future donor support? Donors make all grants possible.

☐ **Yes!** You are welcome to use my story, contact me. ☐ **No.** Please keep my story private.

I guarantee that the information in this request for funding is accurate, complete and true. By signing this application, I give CoxHealth Foundation authorization to obtain and verify any financial or medical information on this application. I understand this support is for CoxHealth services ONLY.

Applicant Signature	**Date**