CoxHealth

FINANCIAL ASSISTANCE APPLICATION

Phone: 417-269-6765 Option 2
Email: FinancialAssistanceApplications@coxhealth.com

Important: YOU MAY BE ELIGIBLE TO RECEIVE DISCOUNTED CARE. Completing this application will help CoxHealth determine if you can receive discounted services or are eligible for other public programs that can help pay for your health care.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form to apply for discounted care within 240 days following the date of initial billing.

Completed applications may be mailed to or dropped off in person at:
Cox North Hospital
Attn: Financial Navigators
1423 N Jefferson Avenue
Springfield, MO 65802

Completed applications may also be faxed to (417)269-0518 or E-mailed to FinancialAssistanceApplications@CoxHealth.com

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

PATIENT INFORMATION

Patient Name	Date of Birth	Patient Social Security No: (Optional and not required)

Patient	Person Responsible for Bill
Resident of Missouri at time of service? __ Yes __ No	Name
Street	Street
City, State ZIP	City, State ZIP
Phone: ( )	Phone: ( )
Email:	Email:

EMPLOYMENT INFORMATION

Patient's Employer	Spouse's/Partner's/Guardian's Employer
Street	Street
City, State ZIP	City, State ZIP
Phone: ( )	Phone: ( )

OTHER INFORMATION

1. Was the patient involved in an accident that led to the need for services?	__ Yes __ No
2. Was the patient a victim of a crime that led to the need for services?	__ Yes __ No
3. Number of persons in the patient?s family and/or household?	
4. Number of persons who are dependents* of the patient?	
5. What are the ages of the dependents* of the patient?	
6. At the time of service or later, was/is the patient divorced or separated or involved in a marital dissolution proceeding?	__ Yes __ No
7. At the time of service or later, was/is the patient a dependent of a parent who is divorced or separated or involved in a marital dissolution proceeding?	__ Yes __ No

8. If yes to either question 6 or 7, then who is responsible for the patient?s medical care per the divorce or separation agreement or order?

Name:_____ Relationship:_____

Address:_____ City, State, Zip:_____

Phone: (_____)_____

*Dependent means a minor or any person who is listed as a dependent on another person?s federal tax return.

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LIST ALL INSURANCE COVERAGES IN THE SECTION BELOW THAT ARE RELATED TO THE SERVICE RECEIVED			
Health Insurance	Insurance Name	Policy Number	Group Number
Health Insurance			
Medicare			
Medicare Supplement			
Medicaid			
Veterans Benefits			

MONTHLY INCOME AND EXPENSES

Attach the following documents as Proof of Income:

A. Most recent Federal tax return
B. Most recent W-2 form and 1099 forms
C. Two (2) most recent pay stubs
D. Written income verification from an employer if paid in cash - if no tax return or W-2
E. Proof of non-filing (IRS Form 4506)

**	Patient	Spouse/Partner	Parents/Guardian
Gross Monthly Wages			
Self-Employment Income			
Social Security			
Social Security Disability			
Private Disability			
Veterans Disability			
Veterans Pension			
Unemployment			
Worker's Compensation			
Retirement Income			
Child Support			
Alimony or Other Spousal Support			
Temporary Assistance for Needy Families (TANF)			
Other, List:			

EXPENSES	MONTHLY EXPENSE
Housing	
Utilities (i.e. Telephone, Gas, Electric, Water)	
Food	
Child Care	
Transportation	
Medical Expenses	
Other Expenses	

**The above table is optional if you are applying for assistance solely relating to outpatient service.

Missouri Health Net, Medicaid or Marketplace Application Confirmation

If you have applied for Missouri Health Net, Medicaid or Marketplace and have not received your determination yet, please indicate the date and county of application below. Please disregard if you are sending your denial letter with your application.

Date of Application _____ County of Application _____

ATTACH OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by CoxHealth, and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application I will be ineligible for Financial Assistance, any Financial Assistance granted to me may be reversed, and I will be responsible for payment of the bill(s).

Patient/Responsible Party Signature:	Date