Application for Cox Family Assistance Fund

Please attach a copy of your last pay stub. (This will not be processed without it.)

Employee's Name_____Date of hire:_____ FT PT

Address_____City_____State_____Zip_____

Social Security #_____ E-Mail Address_____

Dept: _____N S WL FD Mon BJC Pr Ox Gross Income $_____

Spouse Name _____Supervisor name_____

Spouse/ Employer_____ Monthly Gross Income (tips, etc.)$_____

Other Income (Social Security, Unemployment Compensation, Alimony, Child Support, etc.) $_____
Number and ages of children living at home: number_____ages_____
Do you have medical insurance?_____ Do you have Medicaid?_____ Do you have Medicare?_____

ASSETS:
Financial:
Name of Bank_____CD/s/Stocks/Bonds:_____
Amount of Savings:_____Balance in Checking:_____
Real Estate: Do you own your home?_____Where is it financed?_____
Balance:_____Market Value:_____ Monthly Payment_____
Do you own rental property?_____ Income per month:_____ Lot rental_____
Do you own acreage?_____ Number of acres:_____ Monthly Payment_____
Personal Property:
Auto Year, Make and Model _____
Auto Year, Make and Model _____
Truck Year, Make and Model_____
Recreational Vehicle Year, Make and Model_____
Boat Year, Make and Model _____
Farm Machinery Year, Make and Model _____
Livestock_____ _____

MONTHLY EXPENSES:
Rent/Mortgage_____ Utilities_____ Propane _____Telephone_____
Food_____ Gasoline (vehicles)_____ Insurance_____Cell_____
Loan (type/where financed)_____ Balance_____ Pmt._____
Loan (type/where financed)_____ Balance_____ Pmt._____
Credit Card_____Balance_____ Pmt._____
Credit Card_____ Balance_____ Pmt._____

OUTSTANDING MEDICAL EXPENSES:
1._____Balance_____Pmt._____
2._____Balance_____Pmt._____
3._____Balance_____Pmt._____

_____ _____ _____/_____
Applicant's Signature Date Evening Phone Day Phone

Please list on the back the circumstances that have caused you to apply for this fund. Please be as detailed as possible; use an additional sheet of paper if necessary. This application will not be processed without a reference from your supervisor. Please return the application, proof of income, explanation and reference to:

CoxHealth Foundation
3525 S. National, Suite 204 Springfield, MO 65807
(Medical South, Suite 204)
Fax: 269-9599 Phone: 269-7109 E-Mail: lisa.alexander@coxhealth.com