



Application for Patient Service Fund support

The Patient Service Funds are made possible by donors to the CoxHealth Foundation. The goal is to help patients during a time of financial crisis with needs that are not being met due to a lack of insurance, eligibility for state or federal programs, or underinsured issues. Applications are reviewed as received and you will be informed as quickly as possible if you are approved or denied. Eligibility is based on the patient completing all portions of their responsibility of the application process. This program is for financial assistance for CoxHealth patients only.

To apply: PLEASE READ CAREFULLY

CHECK the BOXES to VERIFY YOU HAVE COMPLETED ALL PORTIONS OF THE APPLICATION. IF YOU DO NOT CHECK ALL BOXES, YOUR APPLICATION WILL BE DISCARDED: NO EXCEPTIONS.

- Completed Financial Assistance program with CoxHealth- FOR REQUESTS to help pay HOSPITAL CHARGES only- if you have NO insurance or you are deemed medically indigent. If you have insurance you do not qualify for that program and you can move directly to completing this application to be directed to the "Good Samaritan Fund" requests. See below**
- Completed Fund Application- including an explanation of why you are applying. You may write this on a separate sheet or on the back of the application.
- Attached PROOF of income: tax return, pay stub, disability or SS letter. A minimum of one form must be attached or your application will NOT be reviewed. NO exceptions.
- FOR GOOD SAMARITAN FUND APPLICATIONS ONLY- Have set up a payment plan with CoxHealth for the outstanding balance on your bill and have made a minimum of one payment.
- Have a physician referral for the item/need requested. This needs to be attached or emailed to the CoxHealth Foundation- %lisa.alexander@coxhealth.com

****If you are uninsured, you must have already applied for and have a determination from the CoxHealth Financial Assistance program. If you have not already applied, you may contact Patient Financial Services at 417-269-3117 to request an application be sent to you, or you may print a copy from the CoxHealth website at www.coxhealth.com. A guide explaining the financial assistance program and the application are both available to print. Once this process has been completed, the Good Samaritan Fund committee will consider remaining hospital balances. If you have insurance you will not qualify for financial aid through CoxHealth and should proceed to step 2 of this application.**

Send completed application, proof of income, explanation of need to CoxHealth Foundation, 3525 S. National, Suite 204, Springfield, MO 65807. Fax: 417-269-9599. Applications can also be found online at www.coxhealthfoundation.com, under the Patient Assistance tab. Questions? Call 417-269-7150

Application for Fund: _____

Patient Name: _____ Date of care: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security #: _____ E-Mail Address: _____

Employer: _____ Number of years: _____

Doctor: _____ Monthly Gross Income: \$ _____

Spouse Name: _____ Guardian: _____

Spouse/ Employer: _____ Monthly Gross Income (tips, etc.):\$ _____

Other Income: Please circle and then detail: Social Security \$ _____ Unemployment \$ _____
Alimony\$ _____ Child Support\$ _____ Other:\$ _____

Number and ages of children living at home: Number: _____ Ages: _____

Number of grandchildren living at home: _____ Other family in the home: _____

Do you have medical insurance? _____ With what company: _____

Do you have Medicaid? _____ Do you have Medicare? _____ Other (list) _____

Is your bill related to an accident?: _____ Is there insurance? _____ Workers comp: _____

Explain why you received care at CoxHealth:

ASSETS:

Financial:

Name of Bank _____ CD/s/Stocks/Bonds: _____

Amount of Savings: _____ Balance in Checking: _____

Pension: _____ Retirement funds: _____ Investments: _____

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 _____

Other: _____

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. _____

I verify that the information contained on this application is correct to the best of my knowledge and that I can provide proof of any information stated on this application if requested.

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

Please list 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, or write on the back of this application. A committee reviews the applications and the more information you can provide and the better understanding of your need will assist in making a determination of a grant.