

**Application for CoxHealth Foundation Patient Assistance Grants: Fund**

**Please attach a copy of your last pay stub or previous year taxes and explanation of need.**

**(Application will not be processed without all requested information.)**

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 (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 proof of income. Please return the application, proof of income and explanation 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**