



COXHEALTH FOUNDATION

Application for Patient Assistance Funds

The Patient Assistance Funds are made possible by donors to the CoxHealth Foundation. The goal is to help patients during a time of financial crisis with their medical care to help them on the road back to recovery and good health. Applications are reviewed as received. This program is for financial assistance for medical bills/patient care assistance at CoxHealth only and does not include physician bills. To apply for any of the Patient Assistance Funds for medical bill coverage you must have already received services at CoxHealth. No pre-approvals are made for this source of financial assistance. Thank you.

To apply:

1. Contact CoxHealth’s Financial Aid Office- Christina Kindred at 417-269-8146. Complete the financial aid process through CoxHealth FIRST if you are applying for help with hospital charges. Once this process has been completed, your application will be forwarded to the CoxHealth Foundation for further consideration by the applicable fund. If you do not qualify for the CoxHealth Financial Aid Program, proceed to number 2.
2. Complete the Patient Assistance Fund application.
3. Submit a copy of your last year’s tax returns, a copy of your last pay stub or if on disability or Social Security, a copy that includes the income you receive monthly. Please do not send originals, they will not be returned. A form of income must be included or the application will be considered incomplete and will not be reviewed by the committee.
4. Detail below for the review committee what the circumstances are that have caused you to apply for this grant program. You may attach additional pages if needed. Please be specific as to what you are requesting support for as many of the funds have unique criteria as to what grant funds may be awarded for.
5. Send completed application, form 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. *If all the required materials are not received the application will be considered incomplete and will not be reviewed.*
6. Include your physician/case worker recommendation. This can be emailed to lisa.alexander@coxhealth.com. This is required for assistance with the Bethlehem Fund, Cancer Services Fund, Stroke Fund, Ozarks Dialysis Patient Assistance Fund and Wheeler Heart Fund.

Application - Fund to which you are applying: _____

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. _____

Other: _____

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.

**Return the completed application to:
CoxHealth Foundation
3525 S. National, Suite 204
Springfield, MO 65807
417-269-9599 Fax**