



Application for Patient Assistance

Made possible by donors to the CoxHealth Foundation

Questions or need help completing this application?

Call (417) 269-7150 or email chf@coxhealth.com

Monday – Friday from 8:30 AM – 5:00 PM



The CoxHealth Foundation can help cover:

CoxHealth Medical bills that are NOT in collections.



The CoxHealth Foundation cannot help cover:

Physician bills or bills from other hospitals/clinics.

IMPORTANT: If you are uninsured,

you must keep your account current and out of collections in order for your application for assistance to be processed.

To ensure your account remains current, you will need to set up a payment plan with CoxHealth Financial Services.

The first step is to complete the [CoxHealth Financial Assistance Program application](#).

Contact CoxHealth Financial Services at (417) 269-3177 (choose option #2) or go to <https://www.coxhealth.com/patients-and-visitors/financial-assistance/> for more information.

(Note: The CoxHealth Financial Assistance Program may also provide a discount on your bills of up to 90%.)

After your application is complete,

send your completed application along with required proof of income to:

Mail:

CoxHealth Foundation
3525 S. National, Suite 204
Springfield, MO 65807

Email:

chf@coxhealth.com

Fax:

(417) 269-9599

Please print legibly to prevent delays in processing your application.

APPLICANT INFORMATION

Patient Name:		
Date of Birth:	Phone:	
Email:		
Current Address:		
City:	State:	ZIP:
Spouse's Name:	Guardian Name (if applicable):	
Number of Adults Living at Home:	Number of Children (Under 18) Living at Home:	

EMPLOYMENT / INCOME INFORMATION

Patient Current Employer:		
Spouse's Employer:		
Monthly Household Gross Income: \$	Social Security: \$	Unemployment: \$
Alimony: \$	Child Support: \$	Other Income: \$

⚠ IMPORTANT NOTE ⚠

You **MUST** include proof of income (tax return, pay stub, social security letter, disability letter, etc.) or an explanation of why you are unable to provide this information in order for your application to be processed.
Failure to provide this documentation will delay processing of your application.

INSURANCE

Is your bill related to an accident: ☐ Yes ☐ No	If so, was your accident related to workers' compensation? ☐ Yes ☐ No	
Do you have medical insurance? ☐ Yes ☐ No	Name of your insurance company:	
Do you have Medicaid? ☐ Yes ☐ No	If no, have you applied? ☐ Yes ☐ No	Date:
Do you have Medicare? ☐ Yes ☐ No	Do you have any other medical coverage (i.e. medi-share)? ☐ Yes ☐ No	
	If so, what is this coverage?	

CARE INFORMATION

Physician Name(s): (please list all)

What condition(s) are/were you being treated for? (please list all)		
FINANCIAL ASSETS		
Name of Bank:		
Amount in Checking: \$	Amount in Savings: \$	
CDs / Stocks / Bonds: \$	Pension: \$	
Retirement Funds: \$	Investments: \$	
REAL ESTATE		
Do You Own Your Home: ☐ Yes ☐ No	Balance Owed: \$	
Market Value: \$	Monthly Payment: \$	
Do You Own Rental Property: ☐ Yes ☐ No	If yes, Monthly Income: \$	
Do You Own Acreage (Land): ☐ Yes ☐ No	If yes, Monthly Payment: \$	
PERSONAL PROPERTY		
Vehicle Year:	Make:	Model:
Vehicle Year:	Make:	Model:
Recreational Vehicle Year:	Make:	Model:
Boat Year:	Make:	Model:
Farm Machinery Year:	Make:	Model:
Livestock: ☐ Yes ☐ No	If yes, please list:	
MONTHLY EXPENSES		
Rent/Mortgage: \$	Utilities: \$	Propane: \$
Food: \$	Gasoline: \$	Mobile Phone: \$
Medical Insurance: \$	Auto Insurance: \$	Other: \$
Child Support: \$	Alimony: \$	Other: \$
Loan (type/finance company):		Amount: \$
Loan (type/finance company):		Amount: \$
Credit Card:		Amount: \$
Credit Card:		Amount: \$

REQUIRED SECTION – You MUST fill this out in order for us to process your application.

Tell us your story. Why are you requesting assistance? What circumstances should we consider when reviewing your application? Be as specific as possible – attach additional pages if necessary.

Donors make all patient assistance through this program possible.

If you receive assistance, can we tell your story to encourage future donor support?

☐ **Yes!** You are welcome to use my story, please contact me. ☐ **No.** Please keep my story private.

I guarantee that the information in this request for funding is accurate, complete and true. By signing this application, I give CoxHealth Foundation authorization to obtain and verify any financial or medical information on this application. I understand this support is for CoxHealth services ONLY.

Please understand that the application process can take several months to review.

Applicant Signature (REQUIRED)

Date