



COXHEALTH FOUNDATION

APPLICATION FOR PATIENT ASSISTANCE

The funds for assistance 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. This program is for financial assistance for medical bills/patient care assistance at CoxHealth only and does not include physician bills.

I am applying for assistance with hospital charges.

Note: You must have already received services at CoxHealth. No pre-approvals are made for this source of financial assistance.

1. Attach proof of income: tax return, pay stub, disability or Social Security letter. A minimum of one form must be attached. **Not including income information will result in a delay of the review of your application and possible denial of financial assistance.** Please do not send originals.
2. *If you have no insurance or are deemed medically indigent:* you must have completed the Financial Assistance Program with CoxHealth Patient Financial Services prior to applying for this grant. Contact Patient Financial Services at 417-269-0532 or 417-269-3117 for an application.
3. *If you have insurance:* you do not qualify for that program and should fill out this application.
4. *Whether you have insurance or not:* you must set up a payment plan with CoxHealth Patient Financial Services for the outstanding balance on your bill. Monthly payments must be kept up to date.

Note: Applications are reviewed monthly and you will be informed by letter if you are approved or denied. It may take several months from the time of application receipt to review based on the volume of applications received.

I am applying for assistance with non-covered hospital/prescription/equipment/special needs.

Note: The following situations are examples of what qualify for this grant: Colonoscopies, Prescription Medication, Breast Care (mammography and biopsy, as well as follow-up care), Diabetes Education Classes, home aids and therapies.

1. Attach proof of income: tax return, pay stub, disability or Social Security letter. A minimum of one form must be attached. **Not including income information will result in a delay of the review of your application and possible denial of financial assistance.** Please do not send originals.
2. Detail the circumstances that have caused you to apply for assistance. Please be specific as to what health condition you are being treated for and what impact the request has on your health.
3. *If you are requesting medications or equipment you must also send an estimate of the cost from the pharmacy or medical equipment supplier. Request cannot be approved without the dollar amount required for the request as most funds have limitations.*

Note: Applications are reviewed as received.

Questions? Call 417-269-7150

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

Send completed application, proof of income, and explanation of need to:

CoxHealth Foundation
3525 S. National, Suite 204
Springfield, MO 65807
Fax: 417-269-9599

www.coxhealthfoundation.com

If all the required materials are not received the application will be considered incomplete and will not be reviewed.



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| APPLICANT INFORMATION | | | | | |
|---|--|---------------------|-----------------------------------|--------------------------------------|-----------------|
| Patient Name: | | | | | |
| Date of Birth: | | SSN: | | Phone: | |
| Email: | | | | | |
| Current Address: | | | | | |
| City: | | | State: | ZIP: | |
| Spouse's Name: | | | Guardian Name: | | |
| Number of Children Living at Home: | | | Ages of Children: | | |
| Number of Grandchildren Living at Home: | | | Other Family in the Home: | | |
| EMPLOYMENT/INCOME INFORMATION | | | | | |
| Current Employer: | | | | How long? | |
| Monthly Gross Income: \$ | | Social Security: \$ | | Unemployment: \$ | |
| Alimony: \$ | | Child Support: \$ | | Other Income: \$ | |
| Spouse's Employer: | | | Spouse's Monthly Gross Income: \$ | | |
| INSURANCE COVERAGE | | | | | |
| Is your bill related to an accident: | | Yes | No | Workers Compensation? | |
| | | | | Yes | No |
| Medical Insurance: | | Yes | No | Name of Insurance Co: | |
| Medicaid: | | Yes | No | If no have you applied? Yes No Date: | |
| Medicare: | | Yes | No | Other (list): | |
| CARE INFORMATION | | | | | |
| Physician Name(s): | | | | | |
| Date(s) of Service: | | ER | Inpatient | Outpatient | Urgent Care |
| | | | | | Ambulance Other |
| Explain why you received care at CoxHealth: | | | | | |



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| FINANCIAL ASSETS | | |
|--|-----------------------------|---------------------|
| Name of Bank: | | |
| Amount in Checking: \$ | Amount in Savings: \$ | |
| CD's / Stock's / Bond's: \$ | Pension: \$ | |
| Retirement Funds: \$ | Investments: \$ | |
| REAL ESTATE | | |
| Do You Own Your Home? Yes No | Finance Company: | |
| Balance Owed: \$ | Market Value: \$ | Monthly Payment: \$ |
| Do You Own Rental Property? Yes No | If Yes, Monthly Income: \$ | |
| Do You Own Acreage? Yes No | If Yes, Monthly Payment: \$ | |
| PERSONAL PROPERTY | | |
| Automobile Year: | Make: | Model: |
| Automobile Year: | Make: | Model: |
| Truck Year: | Make: | Model: |
| Recreational Vehicle Year: | Make: | Model: |
| Boat Year: | Make: | Model: |
| Farm Machinery Year: | Make: | Model: |
| Livestock: Yes No | If Yes, 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: \$ |
| OUTSTANDING MEDICAL EXPENSES | | |
| | | Amount: \$ |
| | | Amount: \$ |



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Please list the circumstances that have caused you to apply for this fund. 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 better understanding of your need will assist in making a determination of a grant.

If you receive assistance, can we tell your story to encourage future donor support? Donors make all grants possible.

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

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 Signature

Date