



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