Application for Patient Assistance

1. What we can help cover . . .

_______ Medical bills / patient care services from CoxHealth only.

- Physician bills are NOT covered.

_______ Balances AFTER service(s) have been received.

_______ Balances AFTER insurance has processed.

_______ Bills that are NOT in collections.

2. If you do NOT have insurance . . .

1) First complete the CoxHealth Financial Assistance Program application. Contact CoxHealth Financial Services at (417) 269-0523 or (417) 269-3117 for an application. Provides a DISCOUNT to you on your bills, up to 90%.
2) Please establish a payment plan with CoxHealth Financial Services for the outstanding balance on your bills, showing you are working in good faith to do your part.

3. What we need from you | Use the following for checkboxes . . .

_______ Attach a minimum of one (1) form of proof of income. Examples are:

____ tax return ____ pay stub ____ disability letter ____ Social Security letter

OR explanation of why there is no data attached (who is paying for your expenses)

Not including proof of income will result in a delay of the review of your application and possible denial of financial assistance.

_______ Complete application pages 2-4

All sections must have answers. Do NOT leave any cells blank.

Make sure you sign at the bottom of page 4.

How to send to us . . .

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

Email: chf@coxhealth.com | **Fax:** (417) 269-9599

Questions?? **Call:** (417) 269-7150 | Monday – Friday from 8:30 AM – 5:00 PM

The funds for assistance are made possible by donors to the CoxHealth Foundation.

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		
Patient Current Employer:		How long:
Monthly Gross Income: $	Social Security: $	Unemployment: $
Alimony: $	Child Support: $	Other Income: $
Spouse’s Employer:	Spouse’s Monthly Gross Income: $	

INSURANCE		
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

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	
Physician or provider:	Amount: $
Physician or provider:	Amount: $

Additional medical information:

**Please tell us why you need help and WHAT you need assistance with or for---
meaning what health problem are you having.**

- Use an additional sheet of paper if necessary, or write on the back of this application.
- **DO NOT LEAVE THIS BLANK**. This must be completed for your request to be considered.

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 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.

Applicant Signature	**Date**