Financial Assistance Application

Date Sent: ___________________

Date Returned: _______________

Patient's Name: ____ Age: ______________

Patient's Address: ____

____

Marital Status: __________________ Phone Number: ___________________________

Spouse/Parent: ____

Patient/Guardian SS #: ____

Insurance: ____

Person Responsible for bill: ____

Address: ____

Relationship to Patient: _____________________ Phone Number: __________________

Employer: ____

Employer Address & Phone Number: ____

Employer: ____

Employer Address & Phone Number: ____

If Unemployed, Name of Last Employer: ____

How Long Unemployed: ____

List All Members of Your Household (Including Yourself)

Name	Age	Relationship to Patient
______________________	____	________________
______________________	____	________________
______________________	____	________________
______________________	____	________________
______________________	____	________________
______________________	____	________________
______________________	____	________________
______________________	____	________________

Family Income per Month:

Wages	$ ________________
Social Security Earnings	$ ________________
Food Stamps	$ ________________
Unemployment or Workmen's Comp	$ ________________
Pensions/Strike Benefits	$ ________________
Dividends and Interest	$ ________________
Alimony and/or Child Support	$ ________________
Other	$ ________________

NET WORTH WORKSHEET

NAME: ______________________________ DATE: ______________________

ASSETS	VALUE	LIABILITIES	BALANCE
PERSONAL POSSESSIONS		**DEBTS**	
Cash		Mortgage	
Money in Checking		Vacation Home Mortgage	
Market Value of Home		Home Equity Loan	
Market Value of Vacation Home		Car Loan 1	
Market Value of Any Businesses		Car Loan 2	
Furniture		Credit Card 1	
Art, Antiques & Collectibles		Credit Card 2	
Jewelry		Credit Card 3	
Resale Value of Car I		Student Loans	
Resale Value of Car 2		Bank Loans	
Boats or Other Recreational Vehicles		Private Loans (friends & family)	
Other:		Cash Advances	
SAVINGS AND INVESTMENTS		Medical Bills	
Money in Savings Accounts		Taxes Owed	
Money in Emergency Fund		Alimony/Child Support Owed	
Certificates of Deposit (CDs)		Other Debt 1	
Money Market Accounts		Other Debt 2	
Annuities		**TOTAL LIABILITIES**	
Cash Value of Life Insurance			
Stocks		**TOTAL ASSETS**	
Bonds		**TOTAL LIABILITIES**	
Mutual Funds		**TOTAL NET WORTH (ASSETS MINUS LIABILITIES)**	
Real Estate			
Farm Land			
Other (i.e. trust funds or other assets that provide income equity)			
RETIREMENT SAVINGS			
Employee Pension			
401k or 403(b) Accounts			
IRA Accounts			
Keogh Accounts			
Other:			
TOTAL ASSETS			

This is a true and accurate summary of my financial condition. I have not sheltered assets using any trust funds or other financial instrument nor have I transferred ownership of land or other assets of value that would impact my financial position. I fully understand that if this information is found to be false, any financial assistance will be nullified.

Signature: ______________________________ Date: ______________________

List below Any Medical Bills that You or Your Spouse Owe:

Hospital or Doctor	Monthly Payment	Balance Owed
______________________________	________________	___________________
______________________________	________________	___________________
______________________________	________________	___________________
______________________________	________________	___________________
______________________________	________________	___________________

Monthly Expenses:

Rent	$_______________________/Month
House Payment	$_______________________/Month
Utilities	$_______________________/Month
Food	$_______________________/Month
Telephone	$_______________________/Month
Clothing	$_______________________/Month
Insurance Premiums (Car, Life, Health)	$_______________________/Month
Transportation (Gas)	$_______________________/Month
Recreation	$_______________________/Month
Union Dues	$_______________________/Month
Other Expenses	$_______________________/Month

Have You Applied for Missouri Medicaid? ____

If Yes, When? ____

Please attach a **Copy of Your Current Income Tax Return or a Letter of Non Filing** if you have not filed in the last three years. To obtain a Letter of Non Filing contact Patient Accounts at 573-883-7718 and request a form 4506T.

I verify the information given above is true and I fully understand that if this information is found to be false, the financial arrangements will be nullified.

Patient/Guarantor Signature____

Hospital Financial Assistance Non-Covered Services

This Financial Assistance Program is valid for three months and covers only hospital services. The Financial Assistance Program will not cover any Physician Office Visits, Specialty Clinic Physicians, vision care, dental care, pharmacy and lab tests that we can't perform here at Ste. Genevieve County Memorial Hospital.

A visit to the Emergency Department that is not an emergency will <u>NOT</u> be covered and <u>WILL BE</u> the <u>PATIENT'S RESPONSIBILITY</u>.

Ste. Genevieve County Memorial Hospital Financial Assistance Program will not cover any non-emergent medical diagnostic testing or any elective procedures. The Financial Assistance Program does not guarantee that all services will be covered.

Financial Assistance is available up to 100% if you are insured and up to 50% if you are uninsured. Proof of Medical Insurance is required.

Please note that this financial Assistance ONLY covers services rendered at the hospital. Services obtained by any of the SGCMH employed physicians are NOT included. To get financial assistance incurred by a hospital employed physician you may fill out a separate, short application which can be picked up at any of our physician's clinics.

The interpretation of your diagnostic procedure and therefore, billing the professional component of your radiology diagnostic testing is performed by an outside vendor. This service is not covered by our Financial Assistance Program. You will need to contact them directly regarding any billing questions.

Any services requiring the use of Ste. Genevieve Ambulance District are not covered by this Financial Assistance Program. You will need to contact them with any billing questions.

If you have any questions about the Financial Assistance Program, please contact Patient Accounts at 573-883-7718.

I have read all of the above statements and understand the Financial Assistance Program. I assume full responsibility for any charges incurred for non-emergent services.

______________________________ ______________________

Signature Date