Dear Sir or Madame:

Enclosed is the application for the Assistance Program. Please check the boxes below for what applies to your household and complete the application in full for each income receiving member of the household and sign the authorization to verify information. Submit completed application and supporting documentation to SoutheastHEALTH, Patient Financial Services, 301 S. Broadview, Cape Girardeau, MO 63703.

- ☐ **Complete copies of your most recent Federal Income Tax forms, including all attached schedules/forms**
- ☐ **Current W-2**
- ☐ **2 Current Payroll Stubs showing current payroll and YTD earnings**
- ☐ **Pension and retirement income – Proof of amount per month**
- ☐ **Disability Benefits – Proof of amount per month**
- ☐ **Social Security Benefits – Proof of amount per month**
- ☐ **Unemployment Benefits – Proof of amount per week**
- ☐ **Food Stamps – Proof of amount per month**
- ☐ **Two months of complete bank statements, both checking and savings, summary not acceptable**
- ☐ **Medicaid or Illinois Public Assistance rejection or acceptance letter and a copy of the card**
- ☐ **Proof of income from interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support and any other miscellaneous income sources**

<u>This information is required before the application can be reviewed. If approved for assistance, coverage will go back eight (8) months and forward four (4) months from the date of approval.</u>

For questions, please contact a Customer Service Representative at 573-651-5511.

Thank you,

Customer Service
Financial Assistance Program
SoutheastHEALTH

SoutheastHEALTH

FINANCIAL ASSISTANCE APPLICATION

Completing this application will help SoutheastHEALTH determine if you are eligible to receive free or discounted services or other public programs that can help pay for your healthcare. Complete the application in full and sign the authorization to verify information. Submit completed application and supporting documentation to SoutheastHEALTH, Patient Financial Services, 301 S. Broadview, Cape Girardeau, MO 63703. For questions you may contact a Patient Accounts Representative at 573-651-5511.

Section A – Information regarding Applicant

Full Name – (Last, First, Middle) _____

Current Street Address _____

City _____ State _____ Zip _____ Primary Phone _____

Social Security No. _____/_____/_____ Birth Date _____

Present Employer(s) _____Position(s) _____

Employers Address _____

Supervisor _____ Telephone _____

Present Gross Income (Must include written verification) Salary or Commission $_____ per _____

Section B – Information regarding Spouse or Joint Applicant

Full Name – (Last, First, Middle) _____

Social Security No. _____/_____/_____ Birth Date _____

Present Employer(s) _____Position(s) _____

Employers Address _____

Supervisor _____ Telephone _____

Present Gross Income (Must include written verification) Salary or Commission $_____ per _____

*** Does any member of the household receive Alimony and/or Child Support? _____Yes _____No

If Yes, how much? $_____ per _____ $_____ per _____

****

Minor Dependent's Name	Date of Birth	Relationship	Minor Dependent's Name	Date of Birth	Relationship

Name of Nearest Relative Not Living With You _____

Relationship _____ Address _____

Do you have a checking account? _____Yes _____No If Yes, Bank Name _____

Do you have a savings account? _____Yes _____No If Yes, Bank Name _____

Automobiles:

Make	Model	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list your monthly expenses and any outstanding debt(s) you may have, including: Mortgage, Rent, Utilities, Telephone, Credit Cards, Installment Contracts, Etc (include additional expenses on back).

Creditor	Monthly Payment	Past Due? Yes/No	Creditor	Monthly Payment	Past Due? Yes/No
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

*****You must include CURRENT copies of the following, if applicable to you, for your application to be considered: Federal Income Tax Forms, including Schedule C if you are self-employed. Payroll Stubs, W-2's, Social Security Benefits, Disability Benefits, Unemployment Benefits, Medicaid or Illinois Public Aid Rejection or Acceptance Letter or any other forms of income.**

Everything that I have stated in this application is correct to the best of my knowledge. I understand that SoutheastHEALTH will retain this application whether or not it is approved. SoutheastHEALTH is authorized to check my credit and employment history. This program will only cover eligible hospital bills and any lab or Physician bills if employed by SoutheastHEALTH. It will not cover any outside doctor services, such as Washington University Pathology or any other physician or independent contractor providing services at the Hospital. Those providers will bill their services separately.

Applicant's Signature _____ Date _____

Joint Applicant's Signature _____ Date _____

****

Hospital Use Only:

Account #	Balance	Account#	Balance
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____