



Dear Patient:

Attached is a financial assistance application. This application is required to evaluate your account(s) to see if you qualify for financial assistance with your hospital bill(s). For bills received from providers other than the hospital, you must contact them directly for their billing policies.

Please be sure to fill out both pages of this form, and return them, along with proof of income. The following are required for proof of income.

- A copy of your 2011 income tax return, including all schedules
- A record of earnings statement from the Social Security office if you do not file taxes, if applicable
- A copy of your last two bank statements
- A copy of your two most recent pay stubs, if applicable
- A copy of your food stamps (EBT) eligibility letter, if applicable
- A copy of your Social Security benefits statement, if applicable
- A copy of your support award notice, if applicable
- A copy of your pension funds statement, if applicable
- A copy of your disability award notice, etc., if applicable

We will contact you after receiving your completed forms to let you know if you qualify for assistance with your hospital account(s). Please continue to make payment on your account(s) in the meantime; filling out this form is not a guarantee of assistance.

If you have any questions or need assistance to complete this form, please call 573-348-8380. Thank you for your cooperation.

Patient Financial Services
Lake Regional Hospital

attachment



Patient Financial Statement

Patient Name: Hospital Patient # (applicant)

Applicant: Telephone #

Responsible Party: Telephone # (if different from Applicant)

Permanent Address: Street (no P.O. Box numbers) City State ZIP

Temporary Address: Street (no P.O. Box numbers) City State ZIP

Live with Relative State from which Drivers License is Issued:

Date of Birth: Social Security #: Driver's License #:

Dependents (spouse / legal dependents - list all) Total # of People in Family Unit:

Table with 6 columns: Name, DOB/Age, Relationship, Name, DOB/Age, Relationship

Marital Status: Married Separated Divorced Unmarried (single or widowed)

Employment:

Employer: Telephone:

Address: How long there?

Occupation: Weekly / Bi-weekly / Monthly Salary before Deductions:

Spouse's Employer: Telephone:

Address: How long there?

Occupation: Weekly / Bi-weekly / Monthly Salary before Deductions:

List all Income before Taxes: (Gross wages, salaries, dividends, interest, social security benefits, workers compensation, training stipends, regular support from family members not living in the household, government pensions, private pensions, insurance and annuity payments, income from rents, royalties, estates, and trusts, veterans stipends). List all contributing income.

Type	Amount	W/B/O	Type	Amount	W/B/O
_____	\$ _____	_____	_____	\$ _____	_____
_____	\$ _____	_____	_____	\$ _____	_____
_____	\$ _____	_____	_____	\$ _____	_____

*W = Weekly / B = Bi-weekly / M = Monthly

Other dependent income: _____ \$ _____

Has the patient been granted bankruptcy; and, if so, when? _____

Income

Total Gross Monthly Income
(after withholding taxes) \$ _____

Expenses

Monthly Expenses		Weekly/Biweekly/Monthly
Housing	\$ _____	_____
Food	\$ _____	_____
Utilities (gas / water / electric)	\$ _____	_____
Telephone	\$ _____	_____
Transportation	\$ _____	_____
Debts / Creditors	\$ _____	_____
Insurance (Auto, home, life, medical, disability)	\$ _____	_____
Clothing	\$ _____	_____
Miscellaneous	\$ _____	_____
Total Monthly Expenses	\$ _____	_____

Are there any other circumstances or situations that may help assist in making a determination?

Consideration of this application is based on the applicant and/or patient following through to obtain whatever Medicaid or third party benefits he/she is entitled to receive.

I hereby certify that the information given is true and correct to the best of my knowledge.

Signature of Applicant _____ Date _____
(Primary or Representative)

Signature of Applicant _____ Date _____
(Spouse or Representative)