



Dear Patient:

Enclosed 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 & specialty bill(s). For bills received from your primary care provider(s), and do not have insurance please see the attached slide application that will need to be completed for assistance to cover those bill(s).

***Please note- If you qualify for subsidized insurance under the Affordable Care Act, Medicaid and/or any other insurance, but choose to forgo it, your application cannot be considered for financial assistance.***

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. A copy of your 2018 income tax return, including all schedules***
- b. Record of Earnings statement from the Social Security office if you do not file taxes (if applicable)***
- c. A copy of your last 2 bank statements***
- d. A copy of your 2 most recent pay stubs (if applicable)***
- e. A copy of your Food Stamps (EBT) eligibility letter (if applicable)***
- f. A copy of your social security benefits statement (if applicable)***
- g. A copy of your support award notice (if applicable)***
- h. A copy of your Pension funds statement (if applicable)***
- i. 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.

For any questions or assistance on how to fill out this form, please call 573-348-8380. Thank you for your anticipated cooperation.

Patient Financial Services  
Lake Regional Health System



## Patient Financial Statement

Patient Name: \_\_\_\_\_

Hospital Patient # \_\_\_\_\_  
(applicant)

Applicant: \_\_\_\_\_

Telephone # \_\_\_\_\_

Responsible Party: \_\_\_\_\_  
(if different from Applicant)

Telephone # \_\_\_\_\_

Permanent Address: \_\_\_\_\_  
Street (no PO Box numbers) City State Zip

Temporary Address: \_\_\_\_\_  
Street (no PO 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: \_\_\_\_\_

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 / M*	Type	Amount	W / B / M*
_____	\$ _____	_____	_____	\$ _____	_____
_____	\$ _____	_____	_____	\$ _____	_____
_____	\$ _____	_____	_____	\$ _____	_____

\*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 \$ \_\_\_\_\_

**Expenses**

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

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)



Lake Regional Clinic - \_\_\_\_\_  
**Sliding Fee Scale Application**

It is the policy of this Lake Regional Clinic to provide essential services regardless of the patient’s ability to pay. Discounts are offered based upon family income and size. Please complete the following application and return it to the front desk to determine if you, or members of your family, are eligible for a discount.

The discount will apply to all services received at LRPG NHSC clinics. Services which are purchased from outside agencies, including reference laboratory testing, x-ray interpretation by a consulting radiologist, and any other services, will not be discounted.

In the hope that your financial situation improves, **discounts apply only to services received for six months from the date application is approved.** Future services will require you to reapply. Please inquire at the front desk if you have any questions.

Number of related person(s) living in your household, for whom you are financially responsible, including yourself; \_\_\_\_\_.

**Total Household Income:**

	Annual Income	Household Income	Monthly Income
Self	\$		\$
Dependent Children Under age 18	\$		\$
Other Household	\$		\$
<b>Total</b>	<b>\$</b>		<b>\$</b>

I certify that the family size and income information shown above is correct. I understand that I must provide all sources of income including gross wages, tips, social security, disability, pensions, annuities, veteran’s payments, net business or self-employment, alimony, child support, military, unemployment and public aid, including tax returns and at least three pay stubs to verify income level.

\_\_\_\_\_  
 Patient Name (Print) Date of Birth Signature/Date

\_\_\_\_\_  
 Approved by: (Clinic Manager) Date Expiration Date