FINANCIAL ASSISTANCE EVALUATION

Phone: 660-258-1197 or 660-258-1198
Email: c**ollections@phsmo.org** or **collections2@phsmo.org**

Important: YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE.
Completing this application will help Pershing Health System determine if you can receive free or discounted services or are eligible for other public programs that can help pay for your health care.

Please complete this form and submit it to the hospital or clinics in person or by mail:

Pershing Hospital – 130 East Lockling, Brookfield MO 64628

Community Medical Associates – 130 East Lockling, PO Box 408, Brookfield MO 64628

Meadville Medical Clinic – 101 East Hayward, PO Box 131, Meadville MO 64659

Or, electronically at **www.pershinghealthsystem.com/FAP.html** , or by fax to 660-258-1222 Attn: Collections Dept. A completed application has to be submitted within 240 days following the date of the first post discharge billing statement.

Patient acknowledges the he or she has made a good faith effort to provide all information requested in the application to assist the hospital/clinic in determining whether the patient is eligible for financial assistance.

PATIENT INFORMATION		
Patient Name:	Date of Birth:	Patient Social Security No:

Patient	Person Responsible for Bill
Resident of what county at time of service:	Name:
Street:	Street:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Email:	Email:

EMPLOYMENT INFORMATION	
Patient's Employer:	Spouse's/Partner's/Guardian's Employer:
Street:	Street:
City, State, Zip:	City, State, Zip:
Phone:	Phone:

OTHER INFOMRATION	
1. Was the patient involved in an alleged accident that led to the needs for services?	Yes ______ No
2. Was the patient a victim of an alleged crime that led to the need for services?	Yes ______ No
3. Number of persons in the patient's family and/or household?	
4. Number of persons who are dependents' of the patient?	
5. What are the ages of the dependents of the patient?	
6. At the time of service or later, was/is the patient divorced or separated or involved in a marital dissolution proceeding?	Yes ______ No
7. At the time of service or later, was/is the patient a dependent of a parent who is divorced, separated or involved in a marital dissolution proceeding?	Yes ______ No ______

8. If yes to either question 6 or 7, then who is responsible for the patient's medical care per the divorce or separation agreement or order?

Name: ______________________________ Relationship: ______________

Address: ______________________________ City, State, Zip: ______________

Phone: ______________________________

*Dependent means a minor or any person who is listed as a dependent on another person's federal tax return

LIST ALL INSURANCE COVERAGES IN THE SECTION BELOW THAT ARE RELATED TO THE SERVICE RECEIVED			
Insurance Type	**Insurance Name**	**Policy Number**	**Group Name**
Health Insurance			
Medicare			
Medicare Supplement			
Medicaid			
Veteran's Benefits			

MONTHLY INCOME AND EXPENSES

(Attach the following documents as proof of income)

A. Most recent tax return
B. Most recent w-2 forms and 1099 forms
C. Two (2) most recent pay stubs
D. Written income verification from an employer is paid in cash
E. Proof of non-filing (IRS form 4506)
F. Social security award letter

Income information must be provided in order to process your application

	Patient	Spouse/Partner	Parents/Guardian
Gross Monthly Wages			
Self-employment Income			
Social Security			
Social Security Disability			
Private Disability			
Veteran's Disability			
Veteran's Pension			
Unemployment			
Worker's Compensation			
Retirement Income			
Child Support			
Alimony / Other Spousal Support			
Temporary Assistance for Needy Families (TANF)			
Other, List			

EXPENSES	MONTHLY EXPENSES
Housing:	
Utilities: (i.e.. Telephone, Gas, Electric, Water)	
Food:	
Child Care:	
Transportation:	
Medical Expenses:	
Other Expenses:	

ATTACH OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for these hospital/clinic bill(s). I understand that the information provided may be verified by Pershing Health System, and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for payment of the bill(s).

Patient/Responsible Party Signatures: ______________________ Date: ______________