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 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 2019 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

LAKE REGIONAL HEALTH SYSTEM

Patient Financial Statement

Patient Name:_____ Hospital Patient #_____
(applicant)

Applicant:_____ Telephone #_____

Responsible Party:_____ Telephone #_____
(if different from Applicant)

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	$	
	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)

LAKE REGIONAL MEDICAL GROUP

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:

	Household Income	
	Annual Income	Monthly Income
Self	$	$
Dependent Children Under age 18	$	$
Other Household	$	$
Total	$	$

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