

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

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.

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, for each adult in 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. For questions you may contact a Patient Accounts Representative at 573-651-5511.

Section A – Information regarding Applicant

	-0 0 1-1-				
Full Name – (Last, First, Mic	ddle)				
Physical Address		City		State	Zip
		City			
Social Security No/	/	Birth Date	Primary Phone _		
			Position(s)		
Employers Address					
Supervisor			Telephone		
Current Gross Income/Com	ımission (<u>Must ir</u>	nclude written vo	erification) \$	per	
_					
Section B – Information					
			Relationship to		
·			Primary Phone		
			Position(s)		
Employers Address					
			Telephone		
Current Gross Income/Com	ımission (<u>Must ir</u>	iclude written vo	erification) \$	per	
*** Doos any mambar of th	an hausahald rad	soivo Alimony an	nd/or Child Support? Voc	No	
		receive Alimony and/or Child Support? Yes per \$			
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*******	******	******	*********	******	*****
Minor Dependent's Name	Date of Birth	Relationship	Minor Dependent's Name	Date of Birth	Relationship
Relationship		Address			
Do you have a checking acc	count? Voc	No	If Voc. Bank Name		
			If Yes, Bank Name		
DO YOU HAVE A SAVINGS ACCO	unt: res	INU	If Yes, Bank Name		

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arc		Model		Yea	ar
			ng debt(s) you may hav		
		-	cts, Etc. (include addition		_
reditor	Monthly Payment	Past Due?	Creditor	Monthly Payment	Past Due?
·			6		
·			7		
			8		
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·			10		_
Security Benefits, Dis	ability Benefi	ts, Unemployment	edule C if you are self-e Benefits, Medicaid or		
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