SOUTHEAST HEALTH

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, 1200 N. One Mile Road, Dexter, MO For questions you may contact a Patient Accounts Representative at 573-624-5566.

Section A – Application Type

____ Primary Care Clinic Services Only
____ Hospital & Specialty Clinic Services Only
____ All Services

Section B – Information regarding Applicant

Full Name – (Last, First, Middle) _____
Physical Address _____City_____State_____Zip_____
Mailing Address _____City_____State_____Zip_____
Social Security No.* _____/_____/_____ Birth Date _____Primary Phone_____
Present Employer(s) _____ Position(s) _____
Employers Address _____
Supervisor _____ Telephone _____
Current Gross Income/Commission (Must include written verification) $_____ per _____

Section C – Information regarding Other Household Income Earner / Joint Applicant

Full Name – (Last, First, Middle) _____
Social Security No.* _____/_____/_____ Birth Date _____Primary Phone_____
Present Employer(s) _____ Position(s) _____
Employers Address _____
Supervisor _____ Telephone _____
Current Gross Income/Commission (Must include written verification) $_____ per _____

Does any member of the household receive Alimony and/or Child Support? ___ Yes ___No
If Yes, how much? $_____ per _____ $_____ per _____

Section D – Information regarding Minor Dependent's

Minor Dependent's Name	Date of Birth	Relationship	Minor Dependent's Name	Date of Birth	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

*A social security number is not required when applying for assistance for primary care services only.

Section E – Asset, Expense, and Debt Information

*****Only patients who are above 200% of the Federal Poverty Level are required to provide asset, expense, and debt information. Inf you are unsure if you are above or below 200% of the Federal Poverty Level, you can call a patient accounts representative at 573-624-5566 for assistance.**

Do you have a checking account? ___Yes ___No If Yes, Bank Name _____

Do you have a savings account? ___ Yes ___No If Yes, Bank Name _____

Please list your monthly expenses and any outstanding debt(s) you may have, including: Mortgage, Rent, Utilities, Telephone, Credit Cards, Installment Contracts, Etc (include additional expenses on back).

Creditor	Monthly Payment	Past Due? Yes/No	Creditor	Monthly Payment	Past Due? Yes/No
1. _____	_____	_____	6. _____	_____	_____
2. _____	_____	_____	7. _____	_____	_____
3. _____	_____	_____	8. _____	_____	_____
4. _____	_____	_____	9. _____	_____	_____
5. _____	_____	_____	10. _____	_____	_____

*****You must include CURRENT copies of the following, if applicable to you, for your application to be considered: Federal Income Tax Forms, including Schedule C if you are self-employed, Payroll Stubs, W-2's, Social Security Benefits, Disability Benefits, Unemployment Benefits, and/or any other forms of income. If there is no income reported by these sources, a self-declaration of income can be submitted to explain how the patient meets their basic needs.**

For those patients above 200% of Federal Poverty Level, a copy of a Medicaid or Illinois Public Aid Rejection or Acceptance letter is required to be submitted with the application.

Everything that I have stated in this application is correct to the best of my knowledge. I understand that SoutheastHEALTH will retain this application whether or not it is approved. SoutheastHEALTH is authorized to verify my income. I agree to both an employment history and credit check if my information provided determines that I am above 200% of the Federal Poverty Level. This program will only cover eligible hospital bills and any lab or Physician bills if employed by SoutheastHEALTH. It will not cover any outside doctor services, such as Washington University Pathology or any other physician or independent contractor providing services at the Hospital. Those providers will bill their services separately.

Applicant's Signature _____ Date _____

Joint Applicant's Signature _____ Date _____

Hospital Use Only:

Account #	Balance	Account#	Balance
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____
_____	$_____	_____	$_____