Dear Sir or Madame:

Enclosed is the application for the Assistance Program. Please fill out the application completely, **for each income receiving member of the household**. Please check the boxes below for what applies to your household. Return this letter, your application and applicable documentation to the address listed below.

- ☐ **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**

<u>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.</u>

If you have any questions, please do not hesitate to contact our office.

Patient Accounts
Financial Assistance Program
SoutheastHEALTH
301 S. Broadview
Cape Girardeau, MO 63701
573-651-5511

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.

INSTRUCTIONS: Complete the application in full 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 63841. For questions you may contact a Patient Accounts Representative at 573-624-5566.

Information Regarding Applicant/Guarantor (if patient is a minor):

Applicant Information				
Last Name	First Name	Date of Birth	Social Security Number	
Email Address		Home/Cell Phone		
Mailing Address		City	State	Zip Code
Employer		Monthly Income	Work Phone	
Employer Address		City	State	Zip Code
Co-Applicant Information		Relationship to Applicant		
Last Name	First Name	Date of Birth	Social Security Number	
Email Address		Home/Cell Phone		
Mailing Address		City	State	Zip Code
Employer		Monthly Income	Work Phone	
Employer Address		City	State	Zip Code

Presumptive Eligibility: Uninsured patients who demonstrate one of the Presumptive Eligibility Criteria listed below individually or through benefits provided to their household **may** be eligible to receive free care. We verify eligibility electronically when possible, but may need you to assist us to demonstrate your eligibility.

Circle as many as apply:

WIC	SNAP	Deceased with No Estate
Incarcerated	Homeless	MHDC Housing Assistance

Medicaid Eligibility, but not on the date of service or is a non-covered service

Required Documents:

1. Proof of residence: driver's license or permanent residency card
2. Proof of income: Please provide one or more of the following for each employed household member and sign the statement below.
    - A copy of the most recent tax return
    - A copy of the most recent W-2 or 1099 Forms
    - A copy of the most recent pay stub
    - A statement from your employer if paid in cash
    - Any other verification of income sources as listed below

Please list all sources of income for all household members below, including: employment, self-employment, SSA, disability, child support, alimony, unemployment or worker's compensation, veteran's pension or disability, retirement income, or other income. Please indicate the source and amount of income.

Name of Person Receiving the Income	Income Source	Amount

If you cannot provide any documentation relating to your income, fill out the statement below.

I, ____ (name), certify that I have no documents that

prove my household's monthly income of $__________________________.

Please list your dependent household members below:

Name	Age	Relationship

Please list your monthly expense and any outstanding debts you may have, including, Mortgage / Rent, Utilities, Telephone, Credit Cards, Installment Contracts, etc. below:

Creditor	Telephone #	Monthly Payment	Past Due Yes /No	Balance Remaining

APPLICANT CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for state, federal or local assistance for which I may be eligible to help pay for my hospital / clinic bills. I understand that the information provided may be verified by the SEH, and I authorize SEH 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 the payment of the medical bills. All information obtained in the application process will remain confidential and protected under patient's rights to privacy.

Applicant Signature: ____ Date: _________________

Co-Applicant Signature: ______________________________________ Date: _________________