



**PATIENT INFORMATION**

Patient Name	Date of Birth	Telephone No.	Patient No.
Present Home Street Address	City	State	Zip
Social Security No.	Marital Status	Discharge Diagnosis	
Email	(Circle One): Rent    Own    Live with parents		
Name & Address of Employer	How long employed?	Telephone No.	
Position / Title	Supervisor's Name		
If Unemployed, Last Date & Place of Employment	Position / Title		

**Insurance Coverage**

Insurance Type	Insurance Name	Policy Number	Group Name
Health Insurance			
Medicare			
Medicare Supplement			
Medicaid			
Veteran's Benefits			

**SPOUSE INFORMATION**

Name	Date of Birth	Social Security No.
Email	Name of Employer	
Address of Employer	How long employed?	Employer Telephone No.
Position / Title	Supervisor's Name	
If Unemployed, Last Date & Place of Employment	Position / Title	

**MONTHLY INCOME**

**(Attach the following documents as proof of income, if they apply)**

- 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 if paid in cash
- E. Proof of non-filing (IRS form 4506)
- F. Social security award letter

**Income information must be provided to process your application**

ITEM	<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother	<input type="checkbox"/> Patient <input type="checkbox"/> Spouse <input type="checkbox"/> Father <input type="checkbox"/> Mother
Gross Monthly Wages			
Self-employment Income			
Social Security			
Disability			
Rental Income			
Alimony / Child Support			
Unemployment			
State Assistance			
Food Stamps			
Pension			
Retirement Income			
Other, List			
<b>TOTAL</b>			

## Household Monthly Expenses

Housing:

Utilities:  
(i.e. telephone, gas, electric, water)

Food:

Child Care:

Medical Expenses:

Transportation:

Other Expenses:

**TOTAL:**

**Dependents – list all dependents who reside in the applicant’s home. Attach an additional sheet if necessary.**

NAME	Date of Birth	SPOUSE/PARTNER	PARENT	CHILD (UNDER 21)	OTHER

**Number of people in household:** \_\_\_\_\_ **Number of children under age 21 in the home:** \_\_\_\_\_

**COMMENTS:**

### Patient Agreement

*The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and correct to the best knowledge and belief of the undersigned, subject to the penalties of making a false affidavit or declaration, and are made to obtain financial assistance. The creditor will retain the original or a copy of this application, even if financial assistance is not granted. The undersigned also agrees to allow Pershing Health System to contact any or all of the above references for credit verification.*

Patient Signature

Responsible Party or Spouse Signature

Date

Pershing Health System Representative

Department



**Financial Assistance Policy (FAP) Plain Language Summary** - for Pershing Memorial Hospital, Community Medical Associates, and Meadville Medical Clinic

**Financial Assistance** is available to patients living in Linn, Chariton, Carroll, Adair, Grundy, Livingston, Macon, and Sullivan counties. Patients who meet certain income guidelines may qualify for a partial or full discount on all emergency and medically necessary services. A FAP-eligible individual may not be charged more than the amounts generally billed for emergency or other medically necessary care.

**Applying for Financial Assistance** – you may apply for financial assistance at any time – before, during, or after your care, up to 240 days after your first post-discharge billing statement. A completed application has to be submitted within 240 days following the date of the first post-discharge billing statement. The patient acknowledges that 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.

**ER Co-pays** – is the amount specified on your insurance card, or if nothing is stated, a set amount will be conveyed at the point of service

**Clinic Co-pays** – is the amount specified on your insurance card.

**Additional Languages** – our financial assistance policy, application, or plain language summary can be conveyed at the point of service.

**FINANCIAL ASSISTANCE EVALUATION** – PHONE 660.258.1197 OR 660.258.1198

Email: [collections@phsmo.org](mailto:collections@phsmo.org) or [collections2@phsmo.org](mailto: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 healthcare.

**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 // Phone: 660.258.1197 or 660.258.1198
- **Community Medical Associates** – 130 East Lockling, PO Box 408, Brookfield MO 64628 Phone:660.258.1050
- **Meadville Medical Clinic** – 101 East Hayward, PO Box 131, Meadville MO 64659 // Phone: 660.258.1050

Apply electronically at <https://phsmo.org/financial-assistance>, or by fax to 660.258.1222 (hospital) or 660.258.1052 (clinic) Attn: Collections Dept.