Pershing Health System — Application for Financial Assistance

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	❒ Patient ❒ Spouse ❒ Father ❒ Mother	❒ Patient ❒ Spouse ❒ Father ❒ Mother	❒ Patient ❒ Spouse ❒ Father ❒ 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			
TOTAL			

Household Monthly Expenses

Housing:

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

Food:

Childcare:

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 Health System, 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 determine 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 or 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 to help pay for your healthcare.

Please complete this form and submit it to the hospital or clinics in person or by mail:

- **Pershing Health System** – 130 East Lockling, Brookfield MO 64628
- **Community Medical Associates** – 130 East Lockling, PO Box 408, Brookfield MO 64628
- **Meadville Medical Clinic** – 101 East Hayward, PO Box 131, Meadville MO 64659
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Apply electronically at https://phsmo.org/financial-assistance, or by fax to 660.476.4649 Attn: Collections Dept.