Phelps Health

Date: _____

Account #: _____ Guarantor Name:

Balance: _____

Return By: _____

We understand that unexpected medical expenses can be a financial burden. To qualify for financial assistance you **MUST** be a **lawful Missouri resident** and **reside** in one of the following counties: Phelps, Pulaski, Maries, Dent, Crawford, Texas, Osage, Gasconade, Laclede, Camden or Miller. The application will need to be filled out **completely**, and returned with all requested information attached, by the return date listed above. A self-addressed envelope has been included for your convenience.

Please refer to the instruction/checklist sheet attached. We may require additional information in order to process your application. Your prompt return of the completed application including all necessary supporting documentation is essential and required by the "Return By:" date above. You will be notified by mail as soon as a decision has been made. If you do not qualify, we will be glad to work with you to set up a payment plan.

Please call (573)458-7715 or (800)634-1404 if you have any questions or need assistance to complete this application.

Phelps Health
Patient Financial Services

PHELPS HEALTH
FINANCIAL ASSISTANCE APPLICATION INSTRUCTIONS & CHECKLIST

Applications returned without the appropriate information will be considered incomplete and will not be processed until all information is received.

For questions or assistance with completing the application, please call: (573) 458-7715 or (800) 634-1404

☐ 1. Answer **ALL** of the questions on the following pages.

☐ 2. Provide the following proof of gross year-to-date total income for **ALL** adults in the home:
- ☐ > **Payroll Stubs -** Three (3) most recent payroll stubs with year-to-date total income
- ☐ > **Pension -** Beginning of year pension award letter
- ☐ > **Social Security -** Beginning of year Social Security award letter

Print outs of *monthly* amounts for:
- ☐ > **Unemployment income**
- ☐ > **Child Support**
- ☐ > **Alimony**
- ☐ > **Food Stamps**

☐ 3. **Self-Employed Individuals** please complete the attached ***Self-Employment Balance Sheet.***
If you are self-employed, THIS IS REQUIRED TO COMPLETE YOUR APPLICATION.

☐ 4. Provide a COMPLETE copy of the most recent **Federal Tax Return (1040)** ***with all schedules attached.***
- > If you did not file taxes, please attach a written statement to your application explaining why?
- > If your taxes are self-prepared, please request a copy from the IRS by:
  - > **Call the IRS** at 800-829-1040

☐ 5. **Unemployed Individuals** please attach a written statement to your application explaining the following:
- > Why are you unemployed?
- > How do you pay for living expenses?
- > When will you return to work?
- > Do you qualify for unemployment benefits?
- > If someone else is supporting you, please have that person or persons write a letter to explain and attach it to your application. That letter should be signed, dated, and notarized by your supporter.

☐ 6. **Full-time College Students** If you are a full-time college student and receive any type of student loans, grants, scholarships, financial help from family members, etc., that information **MUST** be included. **IF YOU ARE CLAIMED ON YOUR PARENTS' TAX RETURN**, a copy of their tax return and proof of their recent income is **REQUIRED**.

☐ 7. Provide copies of documentation of the expense categories that apply to you (i.e., cable, phone, insurance, etc.)
- > Do **not** include medical bills from Phelps Health; only medical expenses from other providers. If other providers have granted you charity/financial assistance, we need to know the amount of charity/financial assistance for which you were approved.

☐ 8. **SIGNATURES** are *REQUIRED* for your application to be processed.

☐ 9. Return the application along with all appropriate documentation with **14 days**. A self-addressed envelope is attached.

BY FAX:
573-458-8487
ATTN: PFS/SBO SPECIALIST

IN-PERSON:
Phelps Health
1000 West 10th St., Rolla, MO 65401
Our office is located across from the gift shop in the hospital

BY MAIL:
Attn: PFS/SBO SPECIALIST
Phelps Health
PO Box 220, Rolla, MO 65402

PHELPS HEALTH
FINANCIAL ASSISTANCE APPLICATION

Applications returned without the appropriate information will be considered incomplete and will not be processed until all information is received.

To avoid processing delays of your application, please complete ALL fields that apply.

PATIENT INFORMATION

Patient Name:	DOB	Daytime Telephone Number:	Evening Telephone Number:	
Home Address: ☐Rent ☐Own	County	Mailing Address (if different from home):	Lawful Resident: ☐Yes ☐No	Full-time student? ☐Yes ☐No If yes, start date & school:
Social Security Number: ☐ No Social Security Number	Marital Status	Family Size : (Complete Household Section Below)	Insured: ☐Yes ☐No	Has patient applied for Medicaid, COBRA, or financial assistance?: ☐Yes ☐No If denied, why?
Patient Employed? ☐Yes ☐No	Patient's Employer Name, Address & Phone Number:	Spouse Employed? ☐Yes ☐No ☐N/A	Spouse's Employer Name, Address & Phone Number:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Guarantor Name:	Social Security Number: ☐ No Social Security Number	Telephone Number

ACCOUNT INFORMATION

Please list Phelps Health accounts to be reviewed for financial assistance:

Result of Workers' Comp, Liability or MVA?	Account Number	Balance Due
☐Yes ☐No		
☐Yes ☐No		
☐Yes ☐No		
☐Yes ☐No		
☐Yes ☐No		
☐Yes ☐No		

HOUSEHOLD INCOME INFORMATION

If you do not have any income, please attach a written statement of this and explain how you pay for living expenses.

For self-employment, please complete the attached Self-Employment Balance Sheet.

Last Name,First Name	Relationship	DOB	Monthly Income *(provide documentation)*	Unemployment	Social Security	Pension	Child Support	Food Stamps	Public Assistance	Dividends, Interest, CDs, etc.	Other
	SELF										

PHELPS HEALTH
FINANCIAL ASSISTANCE APPLICATION

To avoid processing delays of your application, please complete ALL fields that apply.

HOUSEHOLD ASSETS					
Family Member Name	**Vehicle (Year/Make/Model)**	**Vehicle Value**	**Real Estate (Primary Residence, rental, etc.)**	**Real Estate Value**	**Other/Value**

Attach a separate sheet for additional asset information, included all required documents.

HOUSEHOLD LIABILITIES *Write N/A on all lines that do not apply*		
Expense	**Monthly**	**Balance Due**
Housing		
Utilities		
Telephone		
Food		
Gasoline		
Child Care		
Insurance		
Other Medical Bills		
Medications		
Loan Payments		
Other Loans		
Credit Cards		
Other:		

All additional documentation specified as required in the Phelps Health Financial Assistance Application Instructions must be attached for your application to be processed. For questions or assistance with completing the application, please call (573) 458-7715 or (800) 634-1404.

PATIENT AGREEMENT

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by the hospital, and I authorize the hospital 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 hospital bill.

_____ Patient Signature Date

_____ Spouse Signature (or Responsible Party) Date

Preferred Method of Contact: ☐ Phone: _____ ☐ E-mail: _____ ☐ Other: _____

PHELPS HEALTH
FINANCIAL ASSISTANCE APPLICATION

To avoid processing delays of your application, please complete ALL fields that apply.

SELF-EMPLOYMENT BALANCE SHEET

BUSINESS INFORMATION

Name of Business:

Type of Business:

Business Address:

BUSINESS ASSETS

(This includes monies in banking accounts, accounts receivable, current liabilities, equity, accounts payable, credit cards, retained earnings, net income, etc.)

Current Total Dollar Amount of Assets in Checking/Savings:

Accounts Receivable:

Total Current Assets:

TOTAL ASSETS:

BUSINESS LIABILITIES

Current Liabilities / Accounts Payable: Total

Accounts Payable:

Total Credit Cards:

TOTAL CURRENT LIBABILITIES:

BUSINESS EQUITY

Opening Balance Equity:

Retained Earnings:

Net Income:

TOTAL EQUITY:

TOTAL LIBABILITIES & EQUITY:

Patient Signature Date

Spouse Signature (or Responsible Party) Date