Saint Francis
HEALTHCARE

Dear Sir or Madame,

Please complete the enclosed patient financial assistance application and return by mail, email or fax to one the following:

Saint Francis Healthcare System
ATTN: Patient Accounts
211 Saint Francis Drive
Cape Girardeau, MO 63703

Email: financialcounselors@sfmc.net

Fax: 573-331-5016

You may also take the application to Saint Francis Medical Center's cashier window. You will receive an approval or denial letter once your application has been processed.

The following documentation is required for the applicant and all adult household members before the application can be processed. To aid in timely processing, this checklist is provided for your convenience:

- ❑ Complete copies of your current federal income tax forms, including all attached schedules/forms (1099s), or IRS Verification of Non-filing (to obtain a copy, call 1-800-829-1040)
- ❑ Current payroll stubs showing current and year-to-date earnings
- ❑ Current bank statements for all accounts (complete; summary not acceptable)

If you have any questions, please contact our office by calling 573-331-5217, option 2.

Thank you.

Financial Assistance Application

Section A: Applicant Information

Full Name (Last, First, Middle): ____

Current Street Address: ____

City: ______________________________________ State: _________ ZIP: ______________

Primary Phone: ____

Social Security Number:______________________ Date of Birth (MM/DD/YYYY): ___________

Employment Status: ☐ Employed ☐ Unemployed

If employed, employer name:__________________________ occupation: _________________

Section B: Spouse/Other Adult Living at Primary Residence Information

Full Name (Last, First, Middle): ____

Social Security Number:______________________ Date of Birth (MM/DD/YYYY): ___________

Employment Status: ☐ Employed ☐ Unemployed

Section C: Dependent information

Dependent Name	Birthdate (mm/dd/yyyy)	Relationship to Applicant
______________________________	___________________	______________________
______________________________	___________________	______________________
______________________________	___________________	______________________
______________________________	___________________	______________________
______________________________	___________________	______________________
______________________________	___________________	______________________

Section D: Financial Information

Do you have a checking account? ☐ Yes ☐ No

Do you have a savings account? ☐ Yes ☐ No

Monthly expenses (mortgage, rent, utilities, telephone, credit cards, installment contract, etc.)

Creditor/Bill	Monthly Payment	Past Due (Yes or No)

Section E: Insurance/Medical Coverage

Do you have insurance? ☐ Yes ☐ No

If no, have you applied for Medicaid? ☐ Yes ☐ No

If yes: what is your yearly deducible? $________ How much has been met? $________

Do you have Medical Coverage thru a government program? ☐ Yes ☐ No

If yes, which program? ____

If Medicaid, do you have a spend down? ☐ Yes ☐ No

If yes, list monthly spend down amount $________

Section F: Requested Service

Have the services you are requesting financial assistance for already been provided? If yes, list accounts, dates of service and balances: ☐ Yes ☐ No

Account Number	Date of Service	Balance

If no, list anticipated service and ordering physician:

Any additional comments:

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Section G: Disclaimer

Everything I have stated in this application is correct to the best of my knowledge. Saint Francis Medical Center is authorized to check my credit and employment history. This program will only cover Saint Francis Healthcare System bills. It will not cover any outside doctor services, such as Cape Radiology or Pathology Associates, or any other physician contractors providing services at Saint Francis Medical Center. Those providers will bill their services separately.

Applicant's Signature: ____________________________________ Date: _________________

Joint Applicant's Signature: ________________________________ Date: _________________