Saint Francis
HEALTHCARE

Dear Sir or Madame,

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

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

Email: financialcounselors@sfmc.net

Fax: 573-331-3887

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.

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

Thank you

Saint Francis HEALTHCARE

Financial Assistance Application

Section A: Information Regarding Applicant

Full Name (Last, First, Middle): _____

Current Street Address: _____

City: _____ State: _____ ZIP Code: _____

Primary Phone: _____ *Social Security Number:_____

Date of Birth (MM/DD/YYYY) _____

Employment Status: ◯ Employed ◯ Unemployed

If employed, your employer name: _____

Your Occupation: _____

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

Full Name (Last, First, Middle): _____

*Social Security Number: _____

Date of Birth (MM/DD/YYYY) _____

Employment Status: ◯ Employed ◯ Unemployed

* Indicates optional , non-required information

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Financial Assistance Application (cont.)

Section C: Dependent Information

Dependent Name:	Date of Birth:	Relationship to Applicant:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Section D: Financial Information

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

Creditor/Bill:	Monthly Payment:	Past Due? (Yes/No):
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Section E: Insurance/Medical Coverage

Do you have insurance: ◯ Yes ◯ No

* If you don't have insurance, have you applied for Medicaid? ◯ Yes ◯ No

If you do have insurance, what is your yearly deducible? _____

How much of the deductible has been met? _____

* Indicates optional , non-required information

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Financial Assistance Application (cont.)

Do you have Medical Coverage through a government program? ◯ Yes ◯ No

If yes, which program? _____

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

If you do have a spend down, please list the monthly spend down amount: _____

Section F: Requested Service

Have the services for which you are requesting financial assistance already been provided? ◯ Yes ◯ No

If yes, please list account numbers, dates of service and balances due:

Account Number:	Date of Service:	Balance Due:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If no, please list anticipated service(s) and ordering physician(s):

_____

_____

_____

Any additional comments?:

_____

_____

_____

_____

_____

_____

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Financial Assistance Application (cont.)

Section G: Disclaimer

I hereby declare that everything that 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: _____

* Indicates optional , non-required information

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