Financial Assistance Application

SSMHealth

Dear Patient

IMPORTANT - YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help SSM Health determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital.

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit it to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance.

CHECKLIST:

- ☐ **Complete and sign/date the application (cannot process without a signature)**
- ☐ **Most recently filed federal tax return document (or non-filing letter)**
- ☐ **Most recent three months of detailed bank statements (checking and savings)**
- ☐ **Most recent two months of gross income verification (all household members)**

Please note: SSM Health will not be able to determine eligibility without proper documentation. Please ensure that you have assembled all the required document. Failure to send all required documents will result in a delay processing your application.

Please send in unaltered and unstapled copies of your documentation. SSM is unable to return original documents being considered for financial assistance.

Patients deemed eligible for Presumptive Charity must still complete this application.

If you need help completing your applications or have any questions, please contact SSM Health Customer Service with questions at **(855) 989-6789**.

By Mail
SSM Health: Patient Business Services
Attn: Financial Assistance
PO Box 28205
St. Louis, MO 63132

By Fax
(314) 989-6734

By Email
financialaid@ssmhealth.com

APPLICATION FOR FINANCIAL ASSISTANCE

Illinois
- □ Good Samaritan Regional Health Center (Mt. Vernon)
- □ St. Mary's Hospital (Centralia)

Missouri
- □ St. Francis Hospital and Health Services
- □ SSM Health St. Mary's Hospital - Audrain
- □ SSM Health St. Mary's Hospital - Jefferson City
- □ SSM Cardinal Glennon Children's Medical Center
- □ SSM DePaul Health Center
- □ SSM St. Louis University Hospital

Missouri
- □ SSM St. Clare Health Center
- □ SSM St. Joseph Health Center
- □ SSM St. Joseph Health Center – Wentzville
- □ SSM St. Joseph Hospital West
- □ SSM St. Mary's Health Center

Oklahoma
- □ Bone & Joint St. Anthony Hospital
- □ St. Anthony Hospital
- □ St. Anthony Shawnee Hospital

Wisconsin
- □ St. Clare Hospital
- □ St. Mary's Hospital (Madison)
- □ St. Mary's Janesville Hospital

Guarantor ID: ______________________
(for office use only)

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

PATIENT INFORMATION

Patient Name:	DOB	Telephone Number	Patient Account #	
Current Street Address:	Apt #	City/State/Zip	☐Rent ☐Own	Live with Parents/Other ☐Yes ☐No If "Yes", supporter statement will be mailed to patient to complete
Social Security Number: ☐ No Social Security Number	Marital Status	Family Size : (Complete Household Section Below)	Insured: ☐Yes ☐No	Have you applied for Medicaid: ☐Yes ☐No Please include determination letter
Employed: ☐Yes ☐No	Employer:	Years Employed?	If unemployed, name of last employer and dates worked:	

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Guarantor Name:	DOB	Telephone Number	Patient Account #	
Current Street Address:	Apt #	City/State/Zip	☐Rent ☐Own	Live with Parents/Other ☐Yes ☐No If "Yes", supporter statement will be mailed to patient to complete
Social Security Number: ☐ No Social Security Number	Marital Status	Family Size : (Complete Household Section Below)	Insured: ☐Yes ☐No	Have you applied for Medicaid: ☐Yes ☐No Please include determination letter
Employed: ☐Yes ☐No	Employer:	Years Employed?	If unemployed, name of last employer and dates worked:	

HOUSEHOLD INFORMATION

Please attach a separate sheet for additional household members, including all required documents.

Last Name	First Name	Relationship	DOB	Employed? (provide documentation)	Full Time Student? (provide documentation)	Monthly Income (provide documentation)	Dependent? (provide documentation)
		SELF		☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		
				☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		☐Yes ☐No ☐ No SSN
				☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		☐Yes ☐No ☐ No SSN
				☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		☐Yes ☐No ☐ No SSN
				☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		☐Yes ☐No ☐ No SSN
				☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		☐Yes ☐No ☐ No SSN
				☐Yes ☐No Employer:	☐Yes ☐No Student Visa? ☐Yes ☐No		☐Yes ☐No ☐ No SSN

Please provide proof of gross income for the following (including but not limited to): wages, social security (award letter), pension(s), unemployment/workman's compensation, alimony/child support, government assistance, disability payments, strike benefits, scholarships/grants, dividends/interest, rental income, cash for services, etc. International students will need to submit student visa and current school schedule. **Bank statements are not verification/proof of income.**

Please note: Depending on the circumstances of your application, we may require additional documents (such as, but not limited to: household bills, medical bills, Attestation of Income and Support, credit reports, and other evidence to support financial need).

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HOUSEHOLD ASSETS**

Only check boxes if no household members have selected assets(s)

Family Member Name	Checking Account(s) Bank Name	Acct Number and Balance	Savings Account(s) Bank Name	Acct Number and Balance	Other (IRA, CD, Etc.)	Balance
Check only if no household members have:	☐No Checking Account(s)		☐No Savings Account(s)		☐No Other Form(s) of Liquid Asset(s)	

Family Member Name	Health Savings/Flex Spending Account (value)	Vehicle (Year/Make/Model)	Vehicle Value	Real Estate (Primary Residence, rental, etc.)	Real Estate Value	Other/Value
Check only if no household members have:	☐No HSA/Flex Account	☐No household vehicle		☐No Real Estate		☐None

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		
Food		
Transportation		
Child Care		
Loans		
Medical Expenses		
Other Expenses (List)		
Other:		

Attach a separate sheet for additional liability information. ***Patients Receiving Care in Illinois Hospitals Only: If patient meets the presumptive eligibility criteria described in 77 ILAC 4500.40 or is otherwise presumptively eligible by virtue of family income, the patient is not required to complete this section of the application****

***** Patients receiving care from an SSM Rural Health Clinic/National Health Service Corps member site, are not required to complete this section of the application*****

PATIENT AGREEMENT

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. 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: ______________________

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Financial Assistance Summary

SSM Health is committed to providing financial assistance to people who are without insurance, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care. SSM Health will provide care of emergency medical conditions to individuals regardless of their ability to pay.

Financial assistance is available on a sliding-scale. Each applicant's financial need is based on Federal Poverty Levels, which includes income and number of family members. Financial need does not consider age, gender, race, social or immigrant status, sexual orientation or religious affiliation. SSM Health limits the amount charged for emergency and medically necessary care provided to patients who are eligible for financial assistance under this policy to not more than gross charges for the care multiplied by the AGB percentage

To apply for financial assistance, you must complete a Financial Assistance Application. Call **(855) 989-6789** or visit **ssmhealth.com/financialaid** to receive a free application. The following documentation should be included with your application:

- Checking & savings account statements (last three months)
- Verification of income (last two months)
- Last year's federal tax return or non-filing letter

Uninsured patients automatically receive a discount on their bill. This will be noted on your billing statement. It does not disqualify you for financial assistance. For uninsured patients, financial assistance is applied after the discount.

Patients without enough insurance coverage also might be eligible for assistance.

Our Financial Counselors can help determine your financial assistance eligibility. If applicable, they can help you apply for Medicaid or setup a payment plan.

Patients are expected to cooperate with SSM Health's Financial Assistance Application process. Eligibility for financial assistance may be restricted to residents in the primary service areas of SSM Health's care sites. In cases when a patient appears eligible for financial assistance, but no evidence is available, SSM Health could use outside agencies to determine eligibility.

Translations of the Financial Assistance Policy, the Billing and Collections policy, the Plain Language Summary, and the Financial Assistance Application are available in the following languages at **ssmhealth.com/financialaid**: Spanish, German, Chinese, Vietnamese, French, Serbo-Croatian, Korean, Russian, Tagalong, Arabic, Hmong, Laotian

A copy of our Billing and Collections Policy, which describes the actions that SSM Health may take in the event of nonpayment, is provided for free upon request.

SSM Health may at any time revise the criteria determining eligibility for financial assistance.

Submit the application and all requested documentation by mail, email, fax, or in person. Be assured that SSM Health understands the sensitivity of your personal information and works hard to protect your privacy.

By Mail
SSM Health: Patient Business Services
Attn: Financial Assistance
PO Box 28205
St. Louis, MO 63132

By Fax
(314) 989-6734

By Email
financialaid@ssmhealth.com

In Person

Please see the Financial Counselor at the Facility in which you received care. Addresses are listed below.

Wisconsin

St. Clare Hospital
707 14th St.
Baraboo, WI 53913

St. Mary's Hospital
700 S. Park St.
Madison, WI 53715

St. Mary's Janesville Hospital
3400 E. Racine St.
Janesville, WI 53546

Illinois

St. Mary's Hospital - Centralia
400 N. Pleasant Ave
Centralia, IL 62801

Good Samaritan Regional Medical Center - Mount Vernon
1 Good Samaritan Way
Mount Vernon, IL 62864

Missouri

SSM Cardinal Glennon Children's Medical Center
1465 S. Grand Blvd.
St. Louis, MO 63104

SSM DePaul Health Center
12303 DePaul Dr.
St. Louis, MO 63044

SSM St. Joseph Health Center
300 First Capitol Drive
St. Charles, MO 63301

SSM St. Joseph Health Center – Wentzville
500 Medical Drive
Wentzville, MO 63385

SSM St. Joseph Hospital West
100 Medical Plaza
Lake Saint Louis, MO 63367

Missouri

SSM St. Mary's Health Center
6420 Clayton Rd.
Richmond Heights, MO 63117

SSM St. Clare Health Center
1015 Bowles Ave.
Fenton, MO 63026

SSM St. Louis University Hospital
3656 Vista At Grand Blvd.
St. Louis, MO 63110

SSM Health St. Mary's Hospital - Jefferson City
2505 Mission Dr.
Jefferson City, MO 65109

SSM Health St. Mary's Hospital – Audrain
620 E. Monroe
Mexico, MO 65265

Missouri

St. Francis Hospital and Health Services
2016 South Main Street
Maryville, MO 64468

Oklahoma

Bone & Joint St. Anthony Hospital
1111 N. Dewey Ave.
Oklahoma City, OK 73103

St. Anthony Hospital
1000 N. Lee
Oklahoma City, OK 73102

St. Anthony Shawnee Hospital
1102 W. Macarthur St.
Shawnee, OK 74804