Financial Assistance Application

Dear Patient

IMPORTANT - YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help SSM Rehabilitation Network determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please complete this form in its entirety including signature and date of completion and submit it with all requested supporting documentation to the hospital in person or by mail to apply for free or discounted.

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.

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 or date)**
- ☐ **Most recently filed federal tax return document (or non-filing letter)**
- ☐ **Most recent two months of gross income verification (all household members)**

Please note: SSM Rehabilitation Network will not be able to determine eligibility without proper documentation. Please ensure that you have assembled all the required documents. 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 Rehabilitation Network 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 stop by the admissions department at the facility where you received service or contact SSM Rehabilitation Network Customer Service at **1-888-868-1103**.

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ALL fields must be completed for application to be processed; indicate N/A on all fields that do not apply.

PATIENT INFORMATION

Patient Name:		DOB	Telephone Number	Patient Account #	
Current Street Address:		Apt #	City/State/Zip	Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced	Family Size : (Complete Household Section Below)
Social Security Number: ☐ No Social Security Number	Insured: ☐ Yes ☐ No	Have you applied for Medicaid: ☐ Yes* ☐ No *Please include determination letter	Employed: ☐ Yes ☐No Self Employed: ☐ Yes ☐No Years Employed:	Employer: 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	Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Divorced	Family Size : (Complete Household Section Below)
Social Security Number: ☐ No Social Security Number	Insured: ☐ Yes ☐ No	Have you applied for Medicaid: ☐ Yes* ☐ No *Please include determination letter	Employed: ☐ Yes ☐No Self Employed: ☐ Yes ☐No Years Employed:	Employer: If unemployed, name of last employer and dates worked:	

HOUSEHOLD INFORMATION

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

First & Last Name	Relationship	DOB SSN?: Yes/No	Employed - Proof Required	Full Time Student? Proof Required	Gross Monthly Income if 18 or over - Check all applicable forms of income and indicate total amount received from all sources. (Documentation for each income source required)
	SELF	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No Student Visa? ☐ Yes ☐No	☐ Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐ Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No Student Visa? ☐ Yes ☐No	☐ Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐ Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No Student Visa? ☐ Yes ☐No	☐ Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐ Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No Student Visa? ☐ Yes ☐No	☐ Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐ Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No Student Visa? ☐ Yes ☐No	☐ Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐ Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐No Student Visa? ☐ Yes ☐No	☐ Wages ☐Unemployment ☐Workman's Compensation ☐Pension(s) ☐Disability ☐ Social Security ☐Alimony/Child Support ☐Government Assistance ☐Other

Please provide proof of gross income for all household members age 18 or over 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: bank statements, 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**
	☐ Personal ☐ Business		☐ Personal ☐ Business			
	☐ Personal ☐ Business		☐ Personal ☐ Business			
	☐ Personal ☐ Business		☐ Personal ☐ Business			
Check 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 Owned (Indicate type - primary residence, rental, etc.) and Purchase Price**	**Current Loan Balance**	**Any Other Asset(s) and Value**
		☐ Business Vehicle		Purchase Price:		Asset: Value:
		☐ Business Vehicle		Purchase Price:		Asset: Value:
		☐ Business Vehicle		Purchase Price:		Asset: Value:
Check if no household members have:	☐ No HSA/Flex Account	☐ No household vehicle		☐ No Real Estate *If no Real Estate Owned, please indicate if you: ☐ Rent ☐ Live with parent(s)/other supporter		☐ None

Attach a separate sheet for additional asset information.

HOUSEHOLD LIABILITIES**		
Expense	**Monthly**	**Balance Due**
Housing		
Utilities		
Food		
Transportation		
Child Care		
Loans		
Medical Expenses		
Other Expenses (List)		
Other:		

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: _____