Financial Assistance Application

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 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, by mail, electronic mail, or fax to apply for free or discounted care.

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.

<u>CHECKLIST:</u>

☐ **Complete all sections of application**

☐ **Sign and date application (If married, spousal signature required)**

☐ **Most recently filed federal tax return (including all schedules) or non-filing letter from IRS**

☐ **Most recent two months of gross income verification of 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 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 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 for assistance at: **(855) 989-6789**.

By Mail
SSM Health: Patient Financial Services
Attn: Financial Assistance
PO Box 411997
St. Louis, MO 63141

By Fax
(314) 989-6734

By Email
financialaid@ssmhealth.com

SSMHealth

APPLICATION FOR FINANCIAL ASSISTANCE

Oklahoma
□ SSM Health Bone & Joint Hospital at St. Anthony
□ SSM Health St. Anthony Hospital - Oklahoma City
□ SSM Health St. Anthony Hospital - Shawnee
□ SSM Health St. Anthony Hospital - Midwest

Missouri
□ SSM Health St. Mary's Hospital - St. Louis
□ SSM Health St. Joseph Hospital - St. Charles
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Missouri
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□ SSM Health St. Clare Hospital - Fenton

Wisconsin
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□ SSM Health St. Mary's Hospital - Janesville
□ St. Agnes Hospital
□ Waupun Memorial Hospital
□ Ripon Medical Center

Illinois
□ SSM Health Good Samaritan Hospital - Mt. Vernon
□ SSM Health St. Mary's Hospital - Centralia

Guarantor ID: _____
(for office use only)

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 □ Divorced Separated □ Widowed	**Family Size:** (Complete Household Section Below)

Social Security Number/ITIN: □ No Social Security Number/ITIN	**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 date of separation:**	

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 □ Divorced Separated □ Widowed	**Family Size:** (Complete Household Section Below)

Social Security Number/ITIN: □ No Social Security Number/ITIN	**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 date of separation:**	

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

First & Last Name	Relationship	Date of Birth & SSN/ITIN	Employed - Proof Required	Full Time Student? *	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	□ No SSN/ITIN	□Yes □No	□Yes □No **Student Visa?** □Yes □No	□Wages □Unemployment □Workman's Compensation □Pension(s) □Disability □Social Security □Alimony/Child Support □Government Assistance □Other
		□ No SSN/ITIN	□Yes □No	□Yes □No **Student Visa?** □Yes □No	□Wages □Unemployment □Workman's Compensation □Pension(s) □Disability □Social Security □Alimony/Child Support □Government Assistance □Other
		□ No SSN/ITIN	□Yes □No	□Yes □No **Student Visa?** □Yes □No	□Wages □Unemployment □Workman's Compensation □Pension(s) □Disability □Social Security □Alimony/Child Support □Government Assistance □Other
		□ No SSN/ITIN	□Yes □No	□Yes □No **Student Visa?** □Yes □No	□Wages □Unemployment □Workman's Compensation □Pension(s) □Disability □Social Security □Alimony/Child Support □Government Assistance □Other
		□ No SSN/ITIN	□Yes □No	□Yes □No **Student Visa?** □Yes □No	□Wages □Unemployment □Workman's Compensation □Pension(s) □Disability □Social Security □Alimony/Child Support □Government Assistance □Other
		□ No SSN/ITIN	□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 including, but not limited to: wages, social security (award letter), pension(s), annuities, unemployment/workman's compensation, alimony/child support, government assistance, disability payments, strike benefits, scholarships/grants, dividends/interest, rental income, cash for services, etc. **Bank statements are not verification/proof of income.**
*International students will need to submit student visa and current school schedule.

Please note: Depending on the circumstances of your application, we may require additional documents including, but not limited to: bank statements, attestation of income, supporter statement, household/medical bills, credit report(s), or other evidence to support financial need.

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HOUSEHOLD ASSETS**

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 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 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 only 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:		

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.

_____   _____
Guarantor Signature   **Date**   **Spouse Signature**   **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 amounts generally billed percentage

To apply for financial assistance, you must complete a financial assistance application. Free applications are available by visiting: **ssmhealth.com/financialaid. A free application may also be obtained by request to (855) 989-6789, MyChart, billingquestions@ssmhealth.com or visiting your facility's financial counselor.** The following documentation is required to be included with your application:

• 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 are available help determine your financial assistance eligibility or answers questions regarding the application process. If applicable, they may help you apply for Medicaid or setup a payment plan.

Patients are expected to cooperate with SSM Health's financial assistance policy and 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.

The financial assistance policy, billing and collections policy, plain language summary, and the financial assistance application are available at **ssmhealth.com/ financialaid** in multiple languages including but not limited to: English, Spanish, Chinese, French, Korean, Russian and Arabic. These documents may also be obtained through mail or email by submitting a request to Customer Service at: **(855) 989-6789, billingquestions@ssmhealth.com or through MyChart**. Financial counselors located on-site at each facility, addresses listed below, may also provide a copy of the above documents in person.

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. Be assured that SSM Health understands the sensitivity of your personal information and works hard to protect your privacy.

All communications concerning disputed debts, including any form of payment tendered as full satisfaction of the debt, must be received at the below address.

Disputed Billing
PO Box 411997
St. Louis, MO 63141

Payments tendered as full satisfaction of a debt that are not sent to this location, will not satisfy the total outstanding debt.

Completed applications or questions regarding financial assistance may be submitted to the following locations:

By Mail
SSM Health: Patient Financial Services
Attn: Financial Assistance
PO Box 411997
St. Louis, MO 63141

By Fax
(314) 989-6734

By Email
financialaid@ssmhealth.com

By Phone
(855) 989-6789

In Person
Please see the financial counselor at the facility in which you received care. Address listed below.

Missouri

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

SSM Health DePaul Hospital - St. Louis
12303 DePaul Drive
St. Louis, MO 63044

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

SSM Health St. Joseph Hospital - Wentzville
500 Medical Drive
Wentzville, MO 63385

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

SSM Health St. Mary's Hospital - St. Louis
6420 Clayton Road
Richmond Heights, MO 63117

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

SSM Health St. Louis University Hospital
1201 S Grand Blvd
St. Louis, MO 63104

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

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

Illinois

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

SSM Health Good Samaritan Hospital - Mt. Vernon
1 Good Samaritan Way
Mount Vernon, IL 62864

Oklahoma

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

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

SSM Health St. Anthony Hospital - Shawnee
1102 W. Macarthur St.
Shawnee, OK 74804

SSM Health St. Anthony Hospital - Midwest
2825 Parklawn Drive
Midwest City, OK 73110

Wisconsin

SSM Health St. Clare Hospital - Baraboo
707 14th St.
Baraboo, WI 53913

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

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

St. Agnes Hospital
430 East Division St
Fond du Lac, WI 54935

Waupun Memorial Hospital
620 W. Brown St
Waupun, WI 53963

Ripon Medical Center
845 Parkside St
Ripon, WI 54971