FINANCIAL ASSISTANCE EVALUATION

BJC HealthCare

Phone: 314-362-8400 or 855-362-8400 Email: patacct@bjc.org Fax: 314-747-6977

Important: YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help BJC HealthCare determine if you can receive free or discounted services or are eligible for other public programs that can help pay for your health 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.

Please complete this form and submit it to the hospital in person, by mail at 600 S. Taylor Ave., Mailstop 90-68-112, St. Louis, MO 63110-9930, by electronic mail to patacct@bjc.org, or by fax 314-747-6977 to apply for free or discounted care within 240 days following the date of initial billing.

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.

PATIENT INFORMATION

Patient Name	Date of Birth	Patient Social Security No. (Optional and not required)

Patient	Person Responsible for Bill
Resident of Illinois at time of service? Yes ____ No ___	Name
Street	Street
City, State ZIP	City, State ZIP
Phone: ( )	Phone: ( )
Email:	Email:

EMPLOYMENT INFORMATION

Patient's Employer	Spouse's/Partner's/Guardian's Employer
Street	Street
City, State ZIP	City, State ZIP
Phone: ( )	Phone: ( )

OTHER INFORMATION

1. Was the patient involved in an alleged accident that led to the need for services?	Yes _____ No _____
2. Was the patient a victim of an alleged crime that led to the need for services?	Yes _____ No _____
3. Number of persons in the patient's family and/or household?	
4. Number of persons who are dependents* of the patient?	
5. What are the ages of the dependents* of the patient?	
6. At the time of service or later, was/is the patient divorced or separated or involved in a marital dissolution proceeding?	Yes _____ No _____
7. At the time of service or later, was/is the patient a dependent of a parent who is divorced or separated or involved in a marital dissolution proceeding?	Yes _____ No _____

8. If yes to either question 6 or 7, then who is responsible for the patient's medical care per the divorce or separation agreement or order?

Name: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Phone: (_____)_____

*Dependent means a minor or any person who is listed as a dependent on another person's federal tax return.

LIST ALL INSURANCE COVERAGES IN THE SECTION BELOW THAT ARE RELATED TO THE SERVICE RECEIVED**

Insurance Type	Insurance Name	Policy Number	Group Number
Health Insurance			
Medicare			
Medicare Supplement			
Medicaid			
Veterans' Benefits			

MONTHLY INCOME AND EXPENSES**

(Attach any one of the following documents as Proof of Income)

A. Most recent tax return
B. Most recent w-2 form and 1099 forms
C. Two (2) most recent pay stubs
D. Written income verification from an employer if paid in cash
E. Proof of non-filing (IRS Form 4506)

Income information must be provided in order to process your application

	Patient	Spouse/Partner	Parents/Guardian
Gross Monthly Wages			
Self-employment Income			
Social Security			
Social Security Disability			
Private Disability			
Veteran's Disability			
Veteran's Pension			
Unemployment			
Worker's Compensation			
Retirement Income			
Child Support			
Alimony or Other Spousal Support			
Temporary Assistance for Needy Families (TANF)			
Other, List			

EXPENSES	MONTHLY EXPENSE
Housing	
Utilities (ie. Telephone, Gas, Electric, Water)	
Food	
Child Care	
Transportation	
Medical Expenses	
Other Expenses	

**EXCEPTIONS: If patient is a resident of Illinois, is uninsured and receives services at Alton Memorial Hospital, Memorial Hospital Belleville or Memorial Hospital East and 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.

If patient is applying for assistance related to services provided at NHSC sites, the patient is not required to complete the insurance and expense sections of the application. NHSC sites include Bourbon Medical office, Cuba Medical Office, Steelville Medical Office, Sullivan Medical Office and Medical Arts Clinic – Farmington.

ATTACH OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

CERTIFICATION: 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 BJC HealthCare, and I authorize them 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 payment of the bill(s).

Patient/Responsible Party Signature: **Date:**