Financial Assistance Evaluation

Please read all instructions carefully and reach out to us with any questions.

Important: **YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE.** Completing this application will help BJC Health ("BJC") 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 FROM BJC. However, a Social Security Number **is required for some public programs**, including Medicaid. Providing a Social Security Number is not required but will help BJC determine whether you qualify for any public programs.

BJC Health includes hospitals and health entities that are part of BJC HealthCare, Saint Luke's, and St. Louis Children's at CoxHealth. To reach our Customer Service team, call or email the following:

BJC HealthCare	**Saint Luke's**	**St. Louis Children's at CoxHealth**
314-362-8400	816-932-5678	417-815-8846
855-362-8400	888-581-9401	833-345-1395
patacct@bjc.org	slhsbilling@saintlukeskc.org	financialassistanceapplications@coxhealth.com

Please complete this form and submit it to the entity at which you are applying for assistance. You may submit the form in person at the service location or per the submission instructions below to apply for free or discounted care. **Financial assistance forms must be submitted within 240 days of the date of initial billing.**

- **BJC HealthCare:** Mail to P.O. Box 790024, St. Louis, MO 63179-0024, email to patacct@bjc.org, or fax to 314-747-6977.
- **Saint Luke's** (Plaza, North, South, East, Allen County, Anderson, Hedrick and Wright Hospitals) and physician balances for Anderson, Hedrick, Wright, and Saint Luke's Physician Group: Mail to Saint Luke's, 901 E. 104th St., Attn: Hospital CBO 6th Floor, Kansas City, MO 64131, or email to slhsbilling@saintlukeskc.org.
- **Saint Luke's Home Care & Hospice:** Mail to Saint Luke's Home Care & Hospice, 901 E. 104th St., Attn: Home Care & Hospice 6th Floor, Kansas City, MO 64131 or email to slhsbilling@saintlukeskc.org.
- **Bishop Spencer Place:** Mail to Bishop Spencer Place, 4301 Madison Ave., Kansas City, MO 64111.
- **St. Louis Children's at CoxHealth:** Mail to St. Louis Children's at CoxHealth, Attn: Financial Counselors, 1423 N. Jefferson Ave., Springfield, MO 65802.

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.

If the patient is a resident of Illinois, is uninsured, and received services at Alton Memorial Hospital, Memorial Hospital in Belleville or Memorial Hospital in Shiloh, complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General at website https://illinoisattorneygeneral.gov/Consumer-Protection/Health-Care/ or by calling 877-305-5145.

Financial Assistance Evaluation

PATIENT INFORMATION			
Patient Name		Date of Birth (DOB)	Patient Social Security Number (Optional and not required)
Race (Optional and not required)	Ethnicity (Optional and not required)	Sex (Optional and not required)	Preferred Language (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 / Person Responsible's Employer	Spouse's / Partner's / Guardian's Name
	Spouse's / Partner's / Guardian's Employer

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. Name, relationship and age of persons who are dependents* of the patient/person responsible?	

*Dependent means a minor or any person who is listed as a dependent on the patient or responsible 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

(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			
Veterans Disability			
Veterans Pension			
Unemployment			
Workers' Compensation			
Retirement Income			
Child Support			
Alimony or Other Spousal Support			
Temporary Assistance for Needy Families (TANF)			
Other — List			

**EXCEPTIONS: If patient is a resident of Illinois, is uninsured, and receives services at Alton Memorial Hospital, Memorial Hospital in Belleville or Memorial Hospital in Shiloh 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 section of the application. NHSC sites for BJC HealthCare include Missouri Baptist Sullivan Hospital Bourbon Medical Office, Cuba Medical Office, Steelville Medical Office, and Sullivan Medical Office; and Parkland Health Center Medical Clinic. NHSC sites for Saint Luke's include Allen County Clinic–Iola, Anderson County Family Care Center, Hedrick Family Care Clinic, Hedrick Medical Center, Hedrick OB GYN Associates, Saint Luke's Mercer County Clinic, Wright Memorial Hospital, and Wright Memorial Physicians Group.

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 acknowledge it is the expectation of BJC Health that 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 Health, and I authorize BJC Health 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: