FINANCIAL ASSISTANCE APPLICATION
National Health Service Clinic Balances ONLY
(If interested in applying for financial assistance on other CoxHealth services, see separate application available at coxhealth.com.)

Phone: 833-775-0018 (toll free) or 417-269-0523
Email: Admissions – FinancialAssistanceApplications@CoxHealth.com

Important: YOU MAY BE ELIGIBLE TO RECEIVE DISCOUNTED CARE for services received at a National Health Service Corp (NHSC) designated clinic. Completing this application will help CoxHealth assess your financial situation and determine if you qualify for a financial assistance discount for services received at the National Health Service Clinic. Discounts do not apply to services or equipment purchased from outside, including reference laboratory testing, drugs, x-ray interpretation by a consulting radiologist, and other such services. You must complete this form every 6 months or if your financial situation changes.

To apply for discounted care, please complete this form and mail or email to the following (or you may drop off in person to the NHSC clinic for which you are applying for assistance):

CoxHealth
Attn: Financial Counselors
1423 N. Jefferson Ave.
Springfield, MO 65802
Fax 417-269-0518

Electronic mail: Admissions - FinancialAssistanceApplications@CoxHealth.com

Note: The application must be received 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 CoxHealth in determining whether the patient is eligible for financial assistance for services received at a National Health Service Clinic.

PATIENT INFORMATION	
Patient Name	**Date of Birth**
Primary Care Provider:	**National Health Service Clinic Name:**
Patient	**Person Responsible for Bill**
Resident of Missouri at time of service? Yes ____ No ___	**Name**
Street	**Street**
City, State ZIP	**City, State ZIP**
Phone: ( )	**Phone:** ( )
Email:	**Email:**

HOUSEHOLD MEMBERS Please list all household members, including those under age 18.		
Name	**Relationship to Patient**	**Date of Birth**

MONTHLY INCOME – FOR ALL HOUSEHOLD MEMBERS AGE 18 AND OVER Please list the monthly amount for all that apply.				
Income Type / List Household Member Name				
Gross wages, salaries, tips, etc.				
Income from business or self-employment				
Child support and/or alimony				
Social security, pension or retirement income				
Interest, dividends, royalties, trust proceeds, etc.				
Any alternative forms of income such as unemployment compensation, workers compensation, public or private assistance from outside the household, etc.				
Total Income				

****DOCUMENTATION REQUIRED – FOR ALL HOUSEHOLD MEMBERS AGE 18 AND OVER****

We must have proof of income to process your application; please provide as indicated below.

- ☐ Most recent complete Federal Tax Return for each household member
- ☐ Two (2) most recent pay stubs for each household member

If you do not have the above listed documents, attach all of the following that are applicable:

- ☐ Most recent W-2 and/or 1099 Forms
- ☐ IRS Verification of Non-filing
- ☐ Written income verification from an employer or letter with self-declaration of income.

CERTIFICATION

I certify the information in this application is true and correct to the best of my knowledge. I understand the information provided may be verified by CoxHealth, and I authorize them to contact third parties to verify the accuracy of the information provided in this application. I understand 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:**

For Office Use Only Below

Approved by: _____ **Date Approved:** _____