Health Care

Mail: MU Healthcare
Financial Counseling
One Hospital Dr, DC003.00
Columbia, MO 65212

Fax:
(573) 884-2294
(573) 884-4979

Drop off: Financial
Counseling Office

Financial Assistance Application. Allow 6-8 weeks for processing. Your application may not be processed if there are incomplete or missing information on page one and/or missing supporting documentation for income and residency.

Demographics

Patient Name: Last:		First:	MI:	DOB:
MRN:	SSN:	Application Date:	Phone number:	( )
Mailing Address:				
Street address or PO Box	*Apt.#*	*City*	*State*	*Zip Code*

Household Information (immediate) – parents and dependent children in household as claimed on tax return. Please check (☑) for the household members you are requesting financial assistance for. Go to page 3 to add more household members.

Name Last	First	MRN	Relationship	DOB	Guarantor	Requesting Assistance (✓)
					☐	☐
					☐	☐
					☐	☐
					☐	☐

Household size: **Marital Status:** ☐ Single ☐ Married ☐ Separated ☐ Divorced/legally separated ☐ Widowed

Rent: Yes ☐ No ☐ **Own:** Yes ☐ No ☐ **Other:**

Residency:

Missouri: Yes ☐ **No** ☐ **U.S. Citizen: Yes** ☐ **No** ☐ **Lawfully in US: Yes** ☐ **No** ☐

Status: Date of entry: Proof provided: Yes ☐ No ☐ NA ☐

EMPLOYMENT STATUS/TAX FILING STATUS/ OTHER. Check the boxes as it applies to you and your household.

Employed?	Self:	Yes ☐	No ☐	Spouse:	Yes ☐	No ☐		
Self Employed?	Self:	Yes ☐	No ☐	Spouse:	Yes ☐	No ☐		
Rental Income?	Self:	Yes ☐	No ☐	Spouse:	Yes ☐	No ☐		
Filed Taxes?	Self:	Yes ☐	No ☐	Spouse:	Yes ☐	No ☐	Joint:	Yes ☐ No ☐

Claimed on someone else's taxes last year? Yes ☐ No ☐

Have you been incarcerated in the past 6 months? Yes ☐ No ☐

Are you enrolled in Food Stamps or Temporary Assistance? Yes ☐ No ☐	If yes, Head of Household (HH) Name:	HH DOB:	HH DCN:

INCOME AND EARNINGS. Provide tax return. If you did not file taxes, provide proof of income, earned and unearned.

	Patient/Guarantor	Amount	Per Mon/Per YR		Spouse	Amount	Per Mon/ Per YR	
Wages	☐		☐	☐	☐		☐	☐
Self-Employment	☐		☐	☐	☐		☐	☐
Rental Income	☐		☐	☐	☐		☐	☐
SS Disability or SSI:	☐		☐	☐	☐		☐	☐
SS Retirement:	☐		☐	☐	☐		☐	☐
Pension/VA benefits:	☐		☐	☐	☐		☐	☐
Unemployment:	☐		☐	☐	☐		☐	☐
Work Compensation:	☐		☐	☐	☐		☐	☐
Child Support/Alimony, Survivor SS Benefits:	☐		☐	☐	☐		☐	☐
Interest/Dividends:	☐		☐	☐	☐		☐	☐
Trust/Annuity:	☐		☐	☐	☐		☐	☐

Tax Filing: (Adjusted Gross Income)	**Self**	**$**	**Spouse**	**$**	**Joint**	**$**

Patient Name: Last: **First:** **MI:** **DOB:**

Please complete this section so that we can explore other assistance options.		
Is the medical care needed a result of an accident?	Yes ☐ No ☐	Date:
Are you a victim of crime with a filed police report?	Yes ☐ No ☐	Date:
Do you have health insurance?	Yes ☐ No ☐	If yes, name of Plan:
Do you have other assistance? (Aflac, HSA, health care sharing ministry plan, etc.)	Yes ☐ No ☐	If yes, name of Plan:
Are you / your spouse offered insurance through your employer?	Yes ☐ No ☐	Yes ☐ No ☐
Have you / your spouse served in the U.S. Military?	Yes ☐ No ☐	Yes ☐ No ☐

Please complete this section to see if you might be eligible for MO HealthNet (Medicaid). If you have questions or need help applying for any MO Health (Medicaid) program, you may contact Financial Counseling for assistance.		
1. Have you / your spouse applied for MO HealthNet in the past 6 months?	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have children in the home under age 19?	Yes ☐ No ☐	
3. Are you pregnant?	Yes ☐ No ☐	Due Date:
If you checked yes for questions 1, 2 or 3 you can Find Help by calling the Health Care Application Helpline at 855-373-9994.		
4. Are you, or will you be unable to work due to a physical or mental disability? If so, how many months? **If yes, please complete the next section.**	Yes ☐ No ☐	3 ☐ 6 ☐ 9 ☐ 12 ☐
5. Have you applied for Social Security Disability? If so, when? **If yes, please complete the next section.**	Yes ☐ No ☐	Date:
6. Are you / your spouse age 65 or older? **If yes, please complete the next section.**	Yes ☐ No ☐	Yes ☐ No ☐

If you checked yes for question 4, 5, or 6, please complete this section. This will help us assess if you qualify for MO HealthNet (Medicaid) based on your resources.

	Patient/Guarantor	**Est Balance**	**Spouse**	**Est Balance**	**Joint**	**Est Balance**
Bank/Debit Cards						
Checking:	☐		☐		☐	
Savings:	☐		☐		☐	
Reloadable / Prepaid Debit:	☐		☐		☐	
Direct Express Card:	☐		☐		☐	
Open Investment Accounts						
Certificate of Deposit (CD):	☐		☐		☐	
Stocks, Bonds, Mutual Funds, Money Market:	☐		☐		☐	
Health Savings Account:	☐		☐		☐	
Retirement Accounts/Cash Value Life Insurance						
IRA (traditional or Roth):	☐		☐		☐	
401(k), 457, 403(b):	☐		☐		☐	
Simple or SEP Plan:	☐		☐		☐	
Trust/Annuity:	☐		☐		☐	
Cash Value Life Insurance:	☐		☐		☐	

Household Assets such as:				
Vehicles (cars, trucks, motorcycles, recreational vehicle, other):	Yes ☐ No ☐	Description of vehicles:		
Real estate property other than for personal residence, business property, or farming:	Yes ☐ No ☐	Description:		Used For:

Patient Name: Last: **First:** **MI:** **DOB:**

Comments/Additional Information

ADDITIONAL Household Members (immediate) as defined on tax return						
Name Last	**First**	**MRN**	**Relationship**	**DOB**	**Guarantor (x)**	**Requesting Assistance (x)**
			self		☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

By signing this form, I agree that:

- The information in this form is correct. It is against the law to give false information.
- MUHC may confirm the information in this form, or get a credit report.

_____ _____

Patient/Guarantor's Signature **Date**

If you are signing on the patient/guarantor's behalf please indicate your relationship to the applicant.

_____ _____

Family Member / Other **Date**

☐ Family Member (relationship) _____

☐ Other (relationship) _____