Black River MEDICAL CENTER
an affiliate of Saint Francis Healthcare System

FINANCIAL ASSISTANCE FORM

REASON FOR APPLICATION (Please Check What Applies)

___ Uninsured (No Insurance)
___ High Insurance Out of Pocket (Co-Insurance/Deductible)
___ Unable to Pay for Services Provided
___ Unable to Make Payment Arrangements

MAIL APPLICATION TO:

Black River Medical Center
Attn: Business Office Manager
217 Physicians Park Drive
Poplar Bluff, MO 63901
(573) 727-9080

INSTRUCTIONS FOR COMPLETING THIS FORM

- **Medicaid Denial Letter Must Accompany This Application**
- Copies of signed Federal Income Tax Return for previous year for household
- Copies of (2) payroll check stubs for each household employer
- Copies of monthly requested financial information including monthly income and expenses
- This application completed, signed and dated
- If approved, it will be good for the calendar year you applied for your household

PATIENT INFORMATION

Patient Name	Account#	Balance
1.		$
2.		$
3.		$
4.		$

RESPONSIBLE PARTY INFORMATION

Relationship to Patient: _____

Responsible Party Name:_____ **SSN#:**_____ **Birth Date:** _____

Address: _____ **City**_____ **State:** _____ **Zip Code:** _____

Phone#: _____ **Cell Phone#:** _____ **Email Address:** _____

Total # of Children: ____ **Total # in Household:** ____

Child(s) Name(s): **Child(s) Age:**

1. _____
2. _____
3. _____
4. _____

Responsible Party Employer: _____ **Phone#:**_____ **Hire Date:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

Spouse's Name: _____ **Birth Date:**_____**SSN#:**_____

Spouse's Employer:_____ **Phone:**_____**Hire Date:**_____

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MONTHLY FINANCIAL INFORMATION

Check and Indicate "Monthly Income"		*Check and Indicate "Monthly Expenses"*		*Check and Indicate "Other"*	
__ None		__ Rent	$_____	__ Checking Account	$_____
__ Veterans	$_____	__ Mortgage	$_____	__ Savings Account	$_____
__ Pension	$_____	__ Utilities	$_____		
__ Child Support	$_____	__ Credit Cards	$_____		
__ Work Comp	$_____	__ Other Cards	$_____		
__ Social Security	$_____	__ Medical	$_____		
__ Unemployment	$_____	__ Pharmacy	$_____		
__ Wages W2/Year	$_____	__ Car Payment	$_____		
__ Alimony	$_____	__ Other Not Listed	$_____		
__ Disability	$_____				
__ Other	$_____				
__ Self Employed	$_____				

All Documentation for Checked Areas Must Accompany This Application

Balance: $_____

% Adjusted: _____ $ Adjusted: _____

Balance Due: _____

CEO/CFO Approval:

_____

Signature Date

COMMENTS:

I hereby state that the information I have provided is true and complete. I authorize the Hospital to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for payment of any and all charges incurred for the services rendered.

X _____ **Date:** _____

Responsible Party Signature

This Application Must be Signed and Dated to be Complete