



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: _____

