WASHINGTON COUNTY
MEMORIAL HOSPITAL

## Financial Program Guidelines and Information Required:

**Patient must live within Washington County to apply for assistance.**

The limit of financial assistance that will be given is $15,000.00. After that amount has been exhausted, you will be responsible for the cost of services received at Washington County Memorial Hospital.

Assistance is valid and active for one year from the date of approval.

Our financial program does not cover expenses of test readings from out radiologist group or any other doctor's reading/testing fees. It does not cover doctor's fee's should you be admitted to out hospital.

If you are approved for financial assistance and are being seen for outpatient services, or have been to the ER, please let the patient accounts department know.

It is the patients responsibility to provide all information needed to apply for financial assistance at the time of service. Failure to do so, will result in patient paying any upfront cost that are due at time of service.

**PROOF OF HOUSEHOLD INCOME IS REQUIRED TO COMPLETE THE APPLICATION PROCESS.** If you do not have it with you at time of services, or return with your financial application, we will not be able to process your application. In addition, a copy of a recently completed Medicaid application or denial letter, less than 30 days old, is required for those who qualify. (SEE ATTACHED MEDICAID ELIGIBILITY DETERMINATION FORM).

Within 10 days of receiving your application, if you fail to return all required information, your application will be discarded.

If you have any questions regarding this process, or the required information, please call our patient accounting department at 573-438-5451 ext. 278 or ext. 313.

Thank you,

Patient Accounts

WASHINGTON
COUNTY
MEMORIAL HOSPITAL

## Determination for Medicaid Eligibility

## Financial Assistance Application

Name: _____

DOB: _____

Address: _____

City: _____ County: _____

Please answer the following four questions to determine if you must apply for Medicaid.

**** If the answer to questions #1 is "No", you must apply for Medicaid.*

1. Are you a U.S. citizen? Yes_____ No_____

**** If you answer "Yes" to questions #2, 3, and 4, you must apply for Medicaid.*

2 Are you under 65 years old and been determined disabled by a physician? Yes_____ No_____

3 Do you have dependents under the age of 18 years old living at home? Yes_____ No_____

4 Are you pregnant? Yes_____ No_____

Staff is available to help you with the Missouri Medicaid eligibility.
Please contact the Business Office at 573-438-5451 ext. 278 or ext. 313

I do certify that the information provided above is true and accurate.

_____

Patient Signature Date

WASHINGTON COUNTY
MEMORIAL HOSPITAL

# APPLICATION FOR FINANCIAL ASSISTANCE

The information requested on this application will be listed for internal use only to determine financial assistance eligibility, WCMH adheres to all HIPPA regulations and guidelines,. The following information is required before the application will be considered: 1) This completed form and 2) Proof of income.

| | |
|---|---|
| **NAME** (LAST, FIRST M. I.) | |
| **ADDRESS** (STREET, CITY, STATE, ZIP) | |
| **PHONE #** | **SOCIAL SECURITY #** |
| **CURRENT/ LAST EMPLOYMENT** (NAME, DATE LAST WORKED) | |
| **TOTAL FAMILY GROSS INCOME (BEFORE TAXES) FOR LAST 12 MONTHS:** | **TOTAL NUMBER IN FAMILY:** |

**PLEASE LIST DEPENDENTS NAME AND AGE**

| NAME | RELATIONSHIP | AGE | NAME | RELATIONSHIP | AGE |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

**DEPENDENTS ARE CHILDREN AS WELL AS ANYONE WHO IS LIVING WITH THE APPLICANT. WE MUST HAVE PROOF OF INCOME FOR EVERYONE LIVING IN THE HOUSEHOLD.**

I certify that the above information is true and accurate to the best of my knowledge. Further, I understand the information submitted is subject to certification by Washington County Memorial Hospital. If any information I have given proves to be untrue, I understand that the hospital; may re-evaluate my financial statues and take whatever legal action becomes appropriate.

Date:_____ Applicant Signature:_____

Office Use Only

Monthly Gross Income:_____ x12=_____ Number in Family:_____

125% poverty guidelines

for family size=_____ _____ Denied _____ Approved Full_____ Partial_____%

Patient Accounts Representative_____ Date_____