Mosaic Medical Center – Albany
705 N. College St., Albany, MO 64402
660.726.3325

MOSAIC MEDICAL CENTER ALBANY

Financial Assistance Application

For Office Use Only
Approved: _____
Denied: _____
Percentage: _____
Date: _____
Application #: _____
Reviewed By:

Applicant's Name: _____

Phone Number: _____

Physical Address, City, State, Zip: _____

_____

Employer: _____

If unemployed, date last worked:_____

Marital Status: ☐Married ☐Single ☐Legally Separated ☐Divorced ☐Widowed

Household Members (including Self):

Name	Date of Birth	Relationship to Applicant	Employed? Y/N	Monthly Gross Income (Before Taxes)

Are there any individuals not listed above that you are financially responsible for? .... ☐Yes ☐No
Are you currently covered under Missouri HealthNet with a Spend Down plan? ..... ☐Yes ☐No
Have you applied for Social Security Disability? ..... ☐Yes ☐No
Do you receive child support or alimony? ..... ☐Yes ☐No
Do you receive unemployment benefits? ..... ☐Yes ☐No
Do you participate in the WIC program? ..... ☐Yes ☐No
Do you receive food stamps or Supplemental Nutrition Assistance (SNAP)? ..... ☐Yes ☐No
Do you receive stipends or funds from the State for providing care (TANF)? ..... ☐Yes ☐No

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Documents that you may need to provide when applying for assistance are:

- ☐ **Wages**: Most recent paycheck stubs dated for 12 weeks prior to application date that show gross income for each household member. May also consider report or letter from employer indicating the gross earned income per pay period for the employee.
- ☐ **Self-Employed**: Most recent month's ledgers showing income and expenses for the business, most recent Federal Tax Return, including the Profit and Loss statement (Schedule C), Federal Tax Exemption form 4029 or letter from the IRS showing non-filing status**.** Additional months of ledgers may be requested.
- ☐ **No Income/Provided Assistance Forms**: Completed and signed for time period without income during the most recent month.
- ☐ **Unemployment Benefits**: A print out from the Unemployment office verifying any funds paid during past 3 months.
- ☐ **Social Security Income**: Letter from Social Security Office showing monthly benefit amount that will reflect gross income for current year.
- ☐ **Pension Income**: Copy of monthly check prior to cashing. Substitute letter from fund/payer's office.
- ☐ **College students**: Account summary showing tuition charges, payments and refunds issued to the student in the most recent term, and last year's tax return for whomever claimed the student as a dependent – student or parent. If claimed as a dependent on parents' income taxes, the parents' household income will be required.
- ☐ ***Additional documents may also be requested*:**
  - ☐ WIC Voucher from Family Support Division
  - ☐ SNAP/Food Stamps Eligibility Letter with all household members listed
  - ☐ Stipend or Funds received from the State for providing care and/or TANIF letter
  - ☐ Marriage Certificate, Divorce Decree, Legal Separation Document
  - ☐ Document of Child Care Assistance
  - ☐ Letter from Employer stating last day of employment, Termination Letter
  - ☐ Income Tax Returns from most recent three years
  - ☐ Bank Statement(s)

I certify that the above information is true and accurate to the best of my knowledge. Further, I will apply for assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my Mosaic Medical Center – Albany and/or physician charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to Mosaic Medical Center – Albany the amount recovered for the charges. If any information I have given proves to be untrue, I understand that Mosaic Medical Center – Albany may re-evaluate my financial status and take whatever action becomes appropriate.

Signature: _____ Date: _____