SSM HOME CARE
10143 Paget Drive
St. Louis, MO 63132
(800) 536-0776 | ssmhomecare.com

APPLICATION FOR FINANCIAL ASSISTANCE

To avoid processing delays of your application, please complete ALL fields that apply to your household.

PATIENT INFORMATION

Patient Name		DOB	Telephone No.		Patient Account #
Present Home Street Address	Apt. No.	City	State	Zip Code	Rent ☐ Own ☐ / Live with parents Yes ☐ No ☐
Social Security No.	Marital Status	Family Size and Ages of each member of household			
Current Employer	How long employed?	Telephone No.	If Unemployed, Last Date & Place of Employment		

RESPONSIBLE PARTY INFORMATION (IF DIFFERENT FROM PATIENT)

Name	DOB	Relationship to Patient	Telephone No.	
Street Address if Different from Patient	Apt. No.	City	State	Zip Code
Social Security No.	Marital Status	Family Size and Ages of each member of household		
Current Employer	How long employed?	Telephone No.	If Unemployed, Last Date & Place of Employment	

SPOUSE INFORMATION

Name	DOB	Social Security No.	Name of Employer
If Unemployed, Last Date & Place of Employment			

MONTHLY INCOME			ASSETS	
ITEM	☐ Patient ☐ Spouse ☐ Parent ☐ Other	☐ Patient ☐ Spouse ☐ Parent ☐ Other	Checking Account(s) (bank name)	Balance
Gross Income				
Overtime			Savings Account(s) (bank name)	Balance
Social Security				
Interest/Dividends			Other (bank) (money market, C.D., IRA)	Balance
Rental Income			Life Insurance (company name)	Cash Value
Alimony/ Child Support			Stocks, Bonds and Mutual Funds (company name)	Values
Unemployment Compensation				
State Assistance			Automobiles/Trucks (make, model & year)	
Supplemental Social Security Income				
Pension			Other Assets (personal, livestock, machinery, motorcycles, RV)	
Disability				
Worker's Compensation			Real Estate (list and describe)	
Other				
TOTAL			**TOTAL ASSETS:**	

Please complete the information as thoroughly as possible so that an accurate assessment of your current financial situation can be determined. Along with the financial statement, all items are required for review, please provide the following items:

1). Most recently filed federal income tax
2). Bank account statement (checking and savings - 3 months)
3). 2 months verification of income (paycheck stubs, unemployment check, social security checks, child support tax documents, etc.)
4). Signature in order to process

Monthly Expenses (provide supporting documentation)	**Monthly Payment**
Rent/Mortgage	_____
Dental/Medical	_____
Utilities	_____
Other	_____
SUB TOTAL	_____

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The original or a copy of this application will be retained by the healthcare provider, even if financial assistance is not granted. The undersigned also agrees to allow this facility to contact any or all of the above reference for credit verification, including credit bureaus.

_____ Patient Signature

_____ Responsible Party or Spouse Signature

_____ Date

_____ Facility Representative / Department

Please return completed application to: SSM at Home: Account Services, 10143 Paget Drive, St. Louis, MO 63132