Southern Obstetrics & Gynecologic Associates (SOGA)	
Financial Assistance Application	
Effective Date: November 1, 2018	**Revision Date(s): 8/19-1/20-1/21-1/22-12/22**

IMPORTANT: You may be eligible to receive free or discounted care

Completing this application will help Southern OB/GYN (SOGA) determine if you are eligible to receive free or discounted services or other public programs that can help pay for your health care.

A Social Security number is required for some public programs, including Medicaid. While providing a Social Security number is not required, it will help SOGA determine whether you qualify for any public programs.

CERTIFICATION STATEMENT

I, _____, (person completing form), acknowledge that I have made a good faith effort to provide all information requested in the application. I understand this is important to assist SOGA in determining eligibility for financial assistance.

I certify the information in this application, to the best of my knowledge, is true and correct. I agree to apply for any state, federal or local assistance for which I may be eligible to help pay the SOGA bill. I understand the information provided in this application may be verified to ensure accuracy. I understand that if I knowingly provide untrue information in this application, I will not be eligible for financial assistance, financial assistance previously granted to me may be reversed and I will be responsible for the payment of the SOGA bill.

Patient Name: _____

Name of Person Completing Application: _____

Patient/Applicant Signature: _____

Date: _____

FINANCIAL ASSISTANCE PROGRAM

Supporting Documentation to be submitted with application

Please provide copies of the following items:

- □ Most recent W-2 withholding statements
- □ Most recent federal/state income tax forms
- □ Paycheck/Unemployment check stubs (past 3 months) or written statement of earnings from your employer (past 3 months).
- □ Most recent Statement of annual benefits from Social Security
- □ Other: letter explaining your situation

Your cooperation with Southern OB/GYN (SOGA) is extremely important in determining your eligibility for financial assistance. Failure to provide this information will be cause to deny financial assistance.

Please submit completed forms along with supporting documentation to SOGA, within 30 days following the date of service, to apply free or discounted care.

Mail: Southern OB/GYN, Attn: Administrator, 9447 Holy Cross Ln, Breese, IL 62230

E-mail: nancy@sogamds.com

Fax: 618-526-7730, Attn: Administrator

For questions, please call 1-(800)-393-7642 and ask for Administrator or Patient Accounts Supervisor

SOGA FINANCIAL ASSISTANCE APPLICATION

Applicant Name (last, first, middle initial)

Date of Birth	**Social Security Number (optional)**	**Phone Number** **Home** _____ **Cell** _____

Home Address (City, State, Zip)

Previous Address (City, State, Zip)

MEMBERS OF HOUSEHOLD

Household Member Name	Date of Birth	Relationship to Applicant	Does Member live at home?		Social Security Number	Is Member currently a SOGA patient	
			Yes	No		Yes	No
1							
2							
3							
4							
5							
6							

****Please provide additional household member information on separate sheet****

PRESUMPTIVE ELIGIBILITY CRITERIA

Does any of the information below apply to you? □ **Yes** □ **No**

If YES, check all that apply. Please include documentation/verification with this application.

- □ Homelessness
- □ Incarceration in penal institution
- □ Deceased with no estate
- □ Enrolled in Temporary Assistance for Needy Families (TANF)
- □ Mental incapacitation with no one to act on patient's behalf
- □ Enrolled in Illinois Housing Development Authority's Rental Housing Support Program
- □ Medicaid eligibility, but not on date of services or for non-covered services

INSURANCE COVERAGE

Are you covered or eligible for any health insurance policy, including foreign coverage, Health Insurance Marketplace, Veteran's benefits, Medicaid and/or Medicare?

□ **Yes** □ **No**

If yes, please provide the following information:

Policyholder Name (last, first, middle initial)

Insurance Carrier Name & Address

Policy Number

Were you covered or eligible under a spouse/partner or former spouse/partner's health insurance policy, foreign coverage policy, Health Insurance Marketplace policy, Veteran's benefits, Medicaid and/or Medicare policy for any or all of your medical services?

□ **Yes** □ **No**

If yes, please provide the following information:

Former spouse/partner name	**Phone Number** **Home** _____ **Cell** _____

Former Spouse/Partner address (City, State, Zip)

EMPLOYMENT

EMPLOYMENT **Household Member #1**	**Employer's Name**	**Employer's Address (City, State, Zip)**	
Salary (gross) $	**Period** □ **Weekly** □ **Bi-Weekly** □ **Twice a Month** □ **Monthly** □ **Annually**	**Length of Employment** _____yr(s) _____mo(s)	**Position**
EMPLOYMENT **Household Member #2**	**Employer's Name**	**Employer's Address (City, State, Zip)**	
Salary (gross) $	**Period** □ **Weekly** □ **Bi-Weekly** □ **Twice a Month** □ **Monthly** □ **Annually**	**Length of Employment** _____yr(s) _____mo(s)	**Position**

UNEARNED INCOME			
Type of Unearned Income	**Household Member**	**Amount**	**Period**
1			
2			
3			
4			
5			
6			

CHILD SUPPORT INCOME			
Child Support Received Name of child	**Name of Person/Parent paying Support**	**Amount**	**Period**
1			□ Weekly □ Monthly □ Annually
2			□ Weekly □ Monthly □ Annually
3			□ Weekly □ Monthly □ Annually
4			□ Weekly □ Monthly □ Annually