Request for Financial Assistance

KIOWA COUNTY MEMORIAL HOSPITAL
GREENSBURG FAMILY PRACTICE

Dear Patient and Family:

In keeping with our mission and core values, Kiowa County Memorial Hospital is committed to providing health care for people regardless of their ability to pay.

Financial Assistance: Medical bills may be difficult to pay. Patients who are unable to pay for all or part of their health care services, regardless of health insurance coverage, may apply for financial assistance by completing and returning this form.

Application Process: To apply for financial assistance, complete and return this form to Kiowa County Memorial Hospital, 721 W Kansas, Greensburg, KS 67054.

One or more of the following information must be included with the application for each household member 18 years of age and older: (if additional documents are requested you will be notified)

- Previous Years Federal Tax Returns – Form 1040 and if self-employed add Schedule C documentation.
- Previous Years W-2s
- Last three (3) months' worth of recent income information including pay stubs, Social Security, unemployment, retirement, pensions, etc.
- Last three (3) Months Bank Statements

Applicants are required to provide:

- KanCare determination letter (Medicaid). If you have not applied please do so by going online to *ApplyforKanCare.ks.gov,* or schedule a time with KCMH presumptive eligibility staff.

Questions? Please call our Business Office
Monday – Friday 8:00 am to 5:00 pm
620-723-3341

This completed application, including the supporting information, should be returned within 30 days of receipt.

By submitting an application for assistance, patients give Kiowa County Memorial Hospital/Greensburg Family Practice consent to make necessary inquiries to confirm financial obligations or references.

Continued on the other side.

KIOWA COUNTY MEMORIAL HOSPITAL
GREENSBURG FAMILY PRACTICE

Request for Financial Assistance

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER

ADDRESS STREET	CITY	STATE	ZIP	TELEPHONE HOME	WORK

DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)	U.S. CITIZEN ❑YES ❑NO

II. Guarantor Information

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP

ADDRESS STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME	WORK	U.S. CITIZEN ❑ YES ❑ NO	DATE OF BIRTH

❑ Please check this box if you have not received services and are applying to pre-qualify.

Have you been approved for Financial Assistance by another Health Care organization? ❑YES ❑NO

If yes, please provide name of organization _____

Are you being referred by a physician or surgeon? ❑YES ❑NO

If yes, please provide name and phone of number of physician _____

III. Household Information – Please indicate ALL people living in your household, including applicant

use additional paper if needed

Please list anyone living in your household (including yourself). Income includes (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, or public/government assistance.

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER NAME	MONTHLY GROSS INCOME PRIOR TO DATE OF SERVICE	INSURED? (circle yes or no) If yes, list insurance (i.e. Blue Cross, PHP, etc.)
1.					Yes or No
2.					Yes or No
3.					Yes or No
4.					Yes or No
5.					Yes or No
6.					Yes or No
7.					Yes or No
8.					Yes or No

IV. Required Information – Must be included with this application

Make sure one or more of the following is included with the application for each household member 18 years and older:

- Previous Years Federal Tax Returns – Form 1040 and if self-employed add Schedule C documentation.
- Previous Years W-2s
- Last three (3) months' worth of recent income information for each person in the household including pay stubs, Social Security, unemployment, retirement, pensions, etc.
- Last three (3) Months Bank Statements

Applicants are required to provide:

- KanCare determination letter (Medicaid). If you have not applied please do so by going online to *ApplyforKanCare.ks.gov,* or schedule a time with KCMH presumptive eligibility staff.

V. Authorization

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge.

X _____ _____

RESPONSIBLE PERSON'S SIGNATURE DATE

Please list any additional information to be considered for Financial Assistance Determination:

_____

_____

_____

_____

_____

_____

_____

_____

_____