Financial Assistance Application Form

In our mission to serve the healthcare needs of residents of Northwest Kansas, Citizens Medical Center Inc. (CMCI) is committed to making care affordable. CMCI offers discounts, payment options and financial assistance to people who cannot afford to pay for medical care, including Emergency Department services. CMCI offers medically necessary services in our facility at a discounted rate or free of charge if you are an eligible candidate under the Financial Assistance Program (FAP).

The financial assistance program applies to all medically necessary hospital inpatient, outpatient and Emergency Department services that are billed by CMCI. The applicant must demonstrate an inability to pay in accordance with the income criteria as established by the current Federal Poverty Guidelines (FPG).

The Financial Assistance policy and procedure is available on request from the CMCI Business Office at (785) 460-4872 or available on the CMCI website.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line. Attach a photocopy of the following proofs of income to the completed form:

1. Last year's tax return statement
2. Social Security check or award letter
3. Last 3 paycheck stubs
4. Last three Bank Statements (checking and savings)

Date	Guarantor
Account No. or Social Security No	Guarantor DOB
Patient Name	Guarantor Phone Number
Street Address	Employer
City, St, Zip	Spouse
Patient DOB	Spouse DOB
Phone Number	Spouse Employer

Citizenship (check one): ☐ U.S. Citizen ☐ Non-US Citizen

Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Separated

Patient	Spouse/Guarantor
☐ Employed Full Time	☐ Employed Full Time
☐ Employed Part Time	☐ Employed Part Time
☐ Not Employed	☐ Not Employed

Names of Dependents (legal deductions on your tax return) Number in household _____

Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	

CITIZENS HEALTH

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Other Coverage Have you applied for Medicaid to cover your services? ☐ Yes ☐ No

Have you applied for a loan to cover your services? ☐ Yes ☐ No

Housing (check one) ☐ Own ☐ Rent ☐ Paid House Payment $_____/month

Utilities Electricity $_____/month Gas $_____/month Water $_____/month

Automobiles Own (How many?)_____ Lease (How many?)_____ Car Payment(s): $_____/month

Bank Accounts/Other Assets **(must answer all three questions)**

Checking Account? ☐ Yes ☐ No $_____

Savings Account? ☐ Yes ☐ No $_____

Additional Assets? ☐ Yes ☐ No Describe _____

Income

Income:	$	/per month	Pension:	$	/per month
Spouse Income:	$	/per month	Farm or Self Employed:	$	/per month
Social Security:	$	/per month	Public Assistance:	$	/per month
Alimony:	$	/per month	Child Support:	$	/per month
Trust Fund:	$	/per month	Survivors Benefit:	$	/per month
Unemployment:	$	/per month	Workman's Comp:	$	/per month
Dividends, Interest, Rent:	$	/per month	Other Income:	$	/per month
TOTAL				$	/per month

(Approval requires proof of income with application)

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. CMCI retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to CMCI to obtain information from any source to verify the statements I (we) have made.

_____ _____

Patient / Guarantor Signature Date

_____ _____

Administrative Signature Date

COPY OF MEDICAID DENIAL LETTER MUST BE ATTACHED TO APPLICATION