FINANCIAL ASSISTANCE APPLICATION

In our mission to serve the healthcare needs of residents of Northwest Kansas, Citizens Health is committed to making care affordable. We offer discounts, payment options, and financial assistance to people who cannot afford to pay for medical care, including Emergency Department services. Citizens Medical Center, NWKS Surgical Associates, and Family Center for Health Care 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 Citizens Medical Center and Family Center for Health Care. 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 by calling 785-460-1777 or available on the Citizens Health website: www.cmciks.com

Instructions: All questions must be answered. If a question does not pertain to you, please write N/A. Return completed application with supporting documents requested in the application to Valerie Ohlrogge, Patient Resource Manager, at Family Center for Health Care: 310 E College Dr, Fax: 785-460-1490, email: vohlrogge@cmciks.com

Patient Information

Name: ______________________________

DOB: ______________________ SSN#: ______________________

Home Phone: (   ) ____________ Cell: (   ) ____________

US Citizen ☐ Yes ☐ No (if no, answer next question) Permanent Resident ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed

Employer Name and Address: ______________________________

If Unemployed, Please provide dates of unemployment period: From________To________

If you are a student and rely on student loans to pay for basic living expenses, please provide copies of student loan amounts and allocations.

How often are you paid: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly

Gross Monthly Salary: ______________ From: __________ To: ____________

Are you claimed on someone else's taxes as a dependent: ☐ Yes ☐ No

Guarantor Information

Relationship to Patient: ______________________________

Guarantor Name: ______________________________

Street Address: ______________________________ City: ______________

State: __________ Zip: __________ Home Phone: (   ) ____________ Cell: (   ) ____________

Household size: ________________ Marital Status: ______________________

Spouse Information

Name: ______________________________

DOB: ______________________ SSN#: ______________________

Employment Status: ☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed

Employer Name and Address: ______________________________

If Unemployed, Please provide dates of unemployment period: From________To________

Insurance Information

Is patient covered by health insurance? ☐ Yes ☐ No

Has patient applied for Medicaid benefits within the last 3 months? ☐ Yes ☐ No

If No, please explain why: ______________________________

____

Has patient been denied Medicaid benefits within the last 3 months? ☐ Yes ☐ No

If patient has been denied Medicaid within the last 3 months, please attach a copy of the denial notice.

Does patient have a lawsuit, settlement, personal injury, work comp or liability claim pending? ☐ Yes ☐ No

Please check all the boxes that apply to the patient and attach supporting documentation

☐ Patient Medicaid eligible but not on date of service, or not eligible for non-covered services.

☐ Patient deceased Date of Death:______________

☐ Patient incarcerated Date of Incarceration:______________

☐ Patient homeless Explain:______________________________

Dependent Information: Approval requires proof of most recent tax return *(If more than 6 use separate page)*

Full Name	DOB	Relationship	Claimed on taxes?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

Total Income Information: Approval requires proof of income (2 months) *(enter monthly amounts)*

Gross Wages:	$ ______	Worker Comp:	$ ______
Pension/Retirement:	$ ______	Child Support	$ ______
Rental Income:	$ ______	Alimony	$ ______
Veterans Benefits:	$ ______	Interest/Dividends:	$ ______
Short/Long Term Disability:	$ ______	SSI/SSDI Social Security:	$ ______
Unemployment	$ ______	Misc:	$ ______

Monetary Asset Information: Approval requires proof of all monetary assets (2 months) *Ex. Checking/Savings statement*

Checking Balance: $ ______ Savings Balance:$ ______CD: $ ______

Stocks/Bonds: $ ______ IRA: $ ______ 401K: $ ______

403b: $______ Other (HSA/FSA) $ ______

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.**

☑ Did you remember to:

☐ Attach 2 months income proof ☐ Attach 2 months monetary asset proof ☐ Attach most recent tax return ☐ Attach Medicaid Denial

Patient/Guarantor Signature: ______________________ Date: ______________

Administrative Signature: ______________________ Date: ______________