



Date issued/Staff Name _____

Return by date _____

CITIZENS HEALTH 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 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 Ohlogge, Patient Resource Manager, at Family Center for Health Care: 310 E College Dr, Fax: 785-460-1490, email: vohlogge@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 Disabled

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: Self Parent/Caregiver Child Spouse Other _____

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 Disabled

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 <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>
_____	_____	_____	Yes <input type="checkbox"/> No <input type="checkbox"/>

Gross Monthly Income: Approval requires proof of income (2 months)

Employment Wages: \$ _____ Worker Comp: \$ _____

Pension/Retirement: \$ _____ Child Support \$ _____

Rental Income: \$ _____ Alimony \$ _____

Veterans Benefits: \$ _____ Interest/Dividends: \$ _____

Short/Long Term Disability: \$ _____ SSI/SSDI Social Security: \$ _____

Unemployment \$ _____ Misc: \$ _____

Asset Information: Approval requires proof of all 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: _____