



CITIZENS
HEALTH

Date issued/Staff Name _____

Return by date _____

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 offer medically necessary services at a discounted rate or free of charge to eligible candidates under the Financial Assistance Program (FAP). The Financial Assistance policy and procedure is available upon request by calling 785-460-1777 or at Citizens Health's 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 requested supporting documents to Valerie Ohlrogge, Patient Resource Manager, by mail: Family Center for Health Care, 310 E College Dr, Colby, KS 67701; Fax: 785-460-1490; or email: vholrogge@cmciks.com

Patient or Parent/Guardian Information

Name: _____ DOB: ____ / ____ / ____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: () _____ Email Address: _____

Marital Status: _____ **Household Size (including applicant):** _____

US Citizen or Permanent Resident Y N SSN: _____ - _____ - _____

Employment Status:

Full Time Part Time Self Employed Student Unemployed Disabled Retired

Employer Name and Address: _____

If unemployed, please provide dates of unemployment period: From _____ To _____

If you rely on student loans to pay for basic living expenses, please provide copies of student loan 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: Y N

Insurance Information

Is the applicant covered by health insurance? Y N

Has the applicant applied for Medicaid benefits within the last 3 months? Y N

Is the applicant pregnant, under the age of 19, a caretaker of a child, over the age of 65, or disabled? Y N

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

Does the patient have a lawsuit, settlement, personal injury, work comp, or liability claim pending? Y N

Please check all the boxes that apply to the patient or household

Would you be interested in finding out if you'd qualify for insurance coverage? Y N

Are there any medications for which you are struggling to pay? If so, please list medications & dosages Y N

Do you feel you are unable to receive necessary medical care, including mental health services, because of the financial burden it may cause? Y N

Spouse Information

Name: _____ DOB: ____ / ____ / ____
 SSN: ____ - ____ - ____ Phone Number: () _____ Email Address: _____
 Employment Status:
 Full Time Part Time Self Employed Student Unemployed Disabled Retired
 Employer Name and Address: _____
 If unemployed, please provide dates of unemployment period: From _____ To _____

Dependent Information: Approval requires proof of most recent tax return (Use separate page if more than 6)

Full Name	DOB	Relationship	Claimed on taxes?		Covered by Insurance?	
			Y	N	Y	N
_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
_____	____/____/____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Gross Monthly Income for all household members: Approval requires proof of the last 2 months income documents

Employment Wages: \$ _____ Workers Comp: \$ _____
 Pension/Retirement: \$ _____ Child Support \$ _____
 Rental Income: \$ _____ Alimony \$ _____
 Short/Long Term Disability: \$ _____ SSI/SSDI Social Security: \$ _____
 Unemployment \$ _____ Misc: \$ _____

Asset Information: Approval requires proof of all assets for the last two months, i.e. last 2 bank statements

Checking Balance: \$ _____ Savings Balance: \$ _____ CD: \$ _____
 Stocks/Bonds: \$ _____ 401K: \$ _____ Other: \$ _____

To help us better understand your needs, please describe your current financial situation, and why you are unable to pay your balance or make monthly payments. Please be specific (Use separate sheet if needed).

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 bank statements Attach most recent tax return Attach Medicaid Denial

Patient/Guarantor Signature: _____ Date: _____

Administrative Signature: _____ Date: _____