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 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 Shasti Crane, Financial Counselor, at Family Center for Health Care: 310 E College Dr, Fax: 785-460-1490, email: scrane@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

Do you have any medications that you are struggling to pay for? If so, please list medications & dosages Y N

_____

_____

_____

Do you feel like you are unable to receive the medical care, including mental health services, you need 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 *(If more than 6 use separate page)*

Full Name	DOB	Relationship	Claimed on taxes?		Covered by Insurance?	
	/ /		Y	N	Y	N
_____	___/ ___ / ___	_____	Y	N	Y	N
_____	___/ ___ / ___	_____	Y	N	Y	N
_____	___/ ___ / ___	_____	Y	N	Y	N
_____	___/ ___ / ___	_____	Y	N	Y	N
_____	___/ ___ / ___	_____	Y	N	Y	N

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 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: _____