Dear Patient,

We at Memorial are proud of our mission to provide high quality comprehensive and compassionate healthcare services to meet the needs of our community.

If you are worried that you will be unable to pay your Memorial Hospital bill in full, please complete and return the attached application to be considered for our Patient Financial Assistance Program.

If you have not recently applied for Kansas Medicaid, please sign the consent in section VI of the application, allowing us to exchange information with an agency that will work with you to determine whether a State sponsored insurance application should be completed.

If you have any questions regarding the application or if you need help filling it out, please call 785.263.2100 and ask for patient financial services.

To view or print a copy of our Financial Assistance Policy go to our website: www.caringforyou.org

Please return the application along with documentation requested to our department within fourteen (14) days.

MEMORIAL HOSPITAL
ATTN: PATIENT FINANCIAL SERVICES
511 NE 10TH STREET
ABILENE KS 67410

APPLICATION FOR FINANCIAL ASSISTANCE

SECTION I: PATIENT INFORMATION (PLEASE PRINT)				
Patient's Name Last First MI				
Address:				
City:			State:	Zip Code:
Home Phone:			Work Phone:	
Social Security No.			Employer:	
Age:	Sex:	Marital Status:	Date of Birth:	

SECTION II: RESPONSIBLE PARTY INFORMATION (PLEASE PRINT)		
Is patient dependent of another person? Y___N___	Relationship to patient:	
Name:	Social Security No.:	
Address:		
City:	State:	Zip Code:
Household Members		
Name	Age	Relationship to Self

SECTION III: EMPLOYMENT & INSURANCE INFORMATION – *RESPONSIBLE PARTY* (PLEASE PRINT)	
Employer:	
Health Insurance: Y_____ N_____	Insurance Name:
Claim Address/City/State/Zip	
Policy Holder Name:	
Policy Holder Relationship to Patient:	
Policy ID Number:	Group Number:

SECTION IV: HOUSEHOLD INCOME & ASSET INFORMATION

Application requires proof of income. Copies of last three months of pay stubs & copy of your last filed tax return must accompany your application. If not working provide copies of your Social Security letter, Unemployment Notification, or any other income notifications.

		Gross Monthly Income
Family's Gross Monthly Wages		$
Unemployment		$
Workers' Compensation		$
Social Security/Disability		$
Child Support/Alimony		$
Pension		$
Interest/Dividends		$
Other/Specify (i.e. rental income, bonds, etc.)		$
Application Requires proof of income: Copies of last three months of pay stubs & copy of your last filed tax return	**TOTAL**	**$**

SECTION V: TO DETERMINE ELIGIBILITY FOR STATE SPONSORED PROGRAM (PLEASE PRINT)

Application requires copy of all household Bank Statements (Two months of most current for each account) along with IRA, 401K, or 401B statements, if applicable.

Do you own your home? Y____N ____	If so, indicate mortgage payment $	Per Month
Do you rent? Y____ N____	If so, indicate rent payment $	Per Month
Do you own more than one vehicle? Y_____ N_____		
Does the total of your bank balances (savings, checking 401K, CD's) exceed $4,000.00 Y_____ N_____		

SECTION VI: STATUS OF MEDICAID ELIGIBILITY (PLEASE PRINT/SIGN)

Applied for Medicaid? Y____N____	If Yes: __Pending __Denied (attach copy of denial) ___Approved
If Approved: Spend Down $_____	

I hereby give my consent to Memorial Hospital to exchange information on this financial assistance application for the purposes of determining whether my household may qualify for assistance with medical bills. I understand this information will be treated as confidential.

Signature	Date
Spouse's Signature	Date

SECTION VII: REQUIRED SIGNATURE FOR PROCESSING OF PATIENT FINANCIAL ASSISTANCE PROGRAM APPLICATION

I understand that this application for Patient Financial Assistance Program is confidential and will be used to determine my eligibility for uncompensated services under the guidelines established by Memorial Hospital. I affirm the information provided is accurate and to the best of my knowledge. If any information that has been given proves to be untrue, I understand that Memorial Hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Signature of Responsible Party	Date

PATIENT FINANCIAL ASSISTANCE PROGRAM

MEMORIAL HOSPITAL is a not-for-profit facility, which renders medically necessary care to all persons in need of such care, regardless of their ability to pay. Memorial's Patient Financial Assistance Program helps people who are unable to pay all of their medical bills. You may qualify for discounts on medical expenses through this program if:

- You do not have health insurance
- Your health insurance doesn't cover all of the medically necessary care you need
- You are not eligible for Medicaid or some other type of insurance
- You meet the financial criteria
- You are a legal resident of Dickinson County, Kansas

MEMORIAL HEALTH SYSTEM
Memorial Hospital
ABILENE Salina Regional Health Center
511 NE 10th Street
Abilene, KS 67410
www.CaringForYou.org