



PO Box 308 | Newton, KS 67114

<b>OFFICE USE</b>	Percentage	_____
	Household Size	_____
	Guideline	_____
	Date Range	_____

## HEALTHCARE ASSISTANCE APPLICATION

See NMC Health's [Healthcare Assistance Policy \(HCA 501R\)](#) for eligibility criteria.

Application Date: \_\_\_\_\_

<b>PATIENT INFORMATION</b>	Last Name	First Name	MI	DOB (MM/DD/YYYY)	Age	SSN
	Address			City	ST	Zip Code
	Phone/Cell #	Work Phone #	Primary Care Physician			
	Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a legal/permanent resident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you file a Federal Tax Return? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you/spouse self-employed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Living Together					
	Please check all boxes that apply to the patient and attach the supporting documentation <input type="checkbox"/> Patient deceased Date of death: _____ (provide a copy of death certificate) <input type="checkbox"/> Patient homeless Explain: _____					

<b>RESPONSIBLE PARTY INFORMATION</b>	<b>PRIMARY GUARANTOR</b>				<b>SECONDARY GUARANTOR</b>			
	Name (Last, First, Middle Initial)				Name (Last, First, Middle Initial)			
	Address				Address			
	City	St	Zip Code		City	St	Zip Code	
	Phone	DOB (MM/DD/YYYY)			Phone	DOB (MM/DD/YYYY)		
	Employer (Name and address)				Employer (Name and address)			
	Employment Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Unemployed				Employment Status <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Unemployed			
	If unemployed, how are you surviving?				If unemployed, how are you surviving?			
Date last unemployment check received:				Date last unemployment check received:				

<b>HOUSEHOLD INFO</b>	HOUSEHOLD MEMBERS – Include Unborn Children (use a separate sheet if needed)							
	Name	DOB	Age	Relationship	SSN	Claimed on Taxes?	Pregnant?	Employed?

<b>PATIENT COVERAGE</b>	Is the patient covered by health insurance or third-party payer? (Check all that apply) <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid <input type="checkbox"/> BCBS <input type="checkbox"/> Other Insurance _____ <input type="checkbox"/> Sharing Group <input type="checkbox"/> Uninsured
	Additional coverage or third-party payers (Check all that apply) <input type="checkbox"/> Lawsuit <input type="checkbox"/> Settlement <input type="checkbox"/> Personal Injury <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Liability <input type="checkbox"/> Crime Victims Compensation
	Expected Settlement \$ _____

HOUSEHOLD INCOME (monthly)	TOTAL INCOME INFORMATION (enter monthly amounts)		
	Gross Wages (before taxes) \$	Unemployment \$	Pension/Retirement \$
	Workers' Comp \$	Rental Income \$	Veterans Benefits \$
	Short/Long Term Disability \$	Interest/Dividends \$	SSI/SSDI Social Security \$
	Other Income \$	Alimony/Child Support \$	Case # _____ County _____

FAMILY RESOURCES (present value)	BANKING AND CURRENT ASSET INFORMATION		
	Checking Account(s) \$	Stocks/Bonds \$	Livestock (market value) \$
	Savings Account(s) \$	Government Cash Assistance \$	Property/Land (market value) \$
	IRA/CD(s) \$	Other Asset(s) \$	Rental Property (market value) \$
	Personal property (Check all that apply) <input type="checkbox"/> Auto <input type="checkbox"/> Motorcycle <input type="checkbox"/> RV <input type="checkbox"/> Boat <input type="checkbox"/> Jet Ski <input type="checkbox"/> Travel Trailer <input type="checkbox"/> Other _____ Total Estimated Value \$ _____		

SUPPORTING DOCUMENT CHECKLIST	COMPLETE THE FINANCIAL ASSISTANCE APPLICATION AND ATTACH COPIES OF THE FOLLOWING. DO NOT SEND ORIGINAL DOCUMENTS. (Items will not be returned. Please attach photocopies only.)	
	<input type="checkbox"/> Healthcare Assistance Application completed and signed	<input type="checkbox"/> Child support and/or alimony payment records
	<input type="checkbox"/> Paycheck stubs or letter from employer verifying income for the three months prior to date of service	<input type="checkbox"/> All checking/savings account statements for the three months prior to date of service (logo/stamped from bank)
	<input type="checkbox"/> Social Security/Disability benefits letter; pension verification letter	<input type="checkbox"/> Most recent Unemployment Determination Letter
	<input type="checkbox"/> Previous year's complete income tax return, including all applicable W-2, 1099, 1098, etc.	<input type="checkbox"/> If others help provide basic living needs, please request a "Statement of Support Letter" from NMC Health to explain how they are assisting you.
	<input type="checkbox"/> Government Cash Assistance benefits letter	<input type="checkbox"/> U.S. Permanent Resident Card, if permanent resident (copy only)

PERSONAL STATEMENT	Please write detailed information in the space provided below describing your current financial situation and why you are unable to pay your balance or make monthly payments. Please be specific. Use a separate sheet if needed.

**Any application without signatures and/or the necessary documentation will not be processed until information is received.**

I wish to apply for financial assistance through NMC Health. I understand that NMC Health expects patients to use all of their available financial resources to pay their medical bills before financial assistance will be granted. I also understand that submission of my application does not guarantee approval for healthcare assistance.

I certify that the information I have provided above is true and complete. By signing this form, I agree to allow NMC Health to check employment and credit history for the purpose of determining my eligibility for financial assistance. I also agree to allow organizations and facilities to release information concerning my financial status to NMC Health for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the above information. I understand NMC Health reserves the right to reverse any charity approval if substantial information was not disclosed, or information was misrepresented or deliberately withheld. In such cases, charity approvals will be reversed and NMC Health will pursue full patient responsibility. If my application is incomplete or information is found to be false or misleading, I understand my application will be denied.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_ Co-Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Mail to:** Midland Group - NMC HCA Team, 1310 Wakarusa Dr, Lawrence, KS 66049 | **Fax:** 785.246.7889 | **Call:** 316.348.3064 or 316.201.9254