NMC health

PO Box 308 | Newton, KS 67114

OFFICE USE	
	Percentage _____
	Household Size _____
	Guideline _____
	Date Range _____

HEALTHCARE ASSISTANCE APPLICATION

See NMC Health's Healthcare Assistance Policy (HCA 501R) for eligibility criteria. Application Date: _____

PATIENT INFORMATION

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?	Are you a legal/permanent resident?	Do you file a Federal Tax Return?	Are you/spouse self-employed?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Living Together

Please check all boxes that apply to the patient and attach the supporting documentation

☐ Patient deceased Date of death: _____ (provide a copy of death certificate)

☐ Patient homeless Explain:_____

RESPONSIBLE PARTY INFORMATION

PRIMARY GUARANTOR			SECONDARY GUARANTOR		
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 ☐ FT ☐ PT ☐ Self-Employed ☐ Student ☐ Unemployed			Employment Status ☐ FT ☐ PT ☐ Self-Employed ☐ Student ☐ Unemployed		
If unemployed, how are you surviving?			If unemployed, how are you surviving?		
Date last unemployment check received:			Date last unemployment check received:		

HOUSEHOLD INFO

HOUSEHOLD MEMBERS – Include Unborn Children (use a separate sheet if needed)

Name	DOB	Age	Relationship	SSN	Claimed on Taxes?	Pregnant?	Employed?

PATIENT COVERAGE

Is the patient covered by health insurance or third-party payer? (Check all that apply)

☐ Medicare ☐ Medicaid ☐ BCBS ☐ Other Insurance_____ ☐ Sharing Group ☐ Uninsured

Additional coverage or third-party payers (Check all that apply)

☐Lawsuit ☐Settlement ☐Personal Injury ☐Workers' Compensation ☐Liability ☐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) ☐ Auto ☐ Motorcycle ☐ RV ☐ Boat ☐ Jet Ski ☐ Travel Trailer ☐ 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.)	
	☐ Healthcare Assistance Application completed and signed	☐ Child support and/or alimony payment records
	☐ Paycheck stubs or letter from employer verifying income for the three months prior to date of service	☐ All checking/savings account statements for the three months prior to date of service (logo/stamped from bank)
	☐ Social Security/Disability benefits letter; pension verification letter	☐ Most recent Unemployment Determination Letter
	☐ Previous year's complete income tax return, including all applicable W-2, 1099, 1098, etc.	☐ If others help provide basic living needs, please request a "Statement of Support Letter" from NMC Health to explain how they are assisting you.
	☐ Government Cash Assistance benefits letter	☐ 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: NMC Health PFS HCA Team, PO Box 308, Newton, KS 67114-0308 | **Drop off Monday-Friday, 8a–4p (closed on holidays)**: NMC Health Surgery Center basement, Room 0017, 800 Medical Center Dr, Newton KS 67114 | **Fax**: 316-804-6280 | **Call**: 316-283-2700, ext 1951