

PO Box 308 | Newton, KS 67114

Percentage	
Household Size	
Guideline	
Date Range	

	Last Name	First Na	First Name			MI	DOB (MN	I/DD/YYYY)	Age S	SN		
PATIENT INFORMATION	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?								employed?	
	☐ Yes ☐ No	☐ Yes	□ Yes □ No			☐ Yes ☐ No ☐ Yes			s 🗆 No	⊔ No		
	Marital Status: Single Married Divorced Legally Separated Widowed Living Together											
	Please check all boxes that apply to the patie											
_	☐ Patient deceased Date of dea							te)				
	☐ Patient homeless Explain:											
	PRIMARY GUARA	NTOR				SECONDARY GUARANTOR						
NO	Name (Last, First, Middle Initial)				Name (Last, First	, Middle Initia	al)				
SLE PARTY INFORMATION	Address Ad				Address	Address						
	City	St	Zip Code		City	City St Zip Code					ode	
	Phone	DOB	DOB (MM/DD/YYYY)		Phone	Phone DOB (MM/DD/YYYY)					D/YYYY)	
	Employer (Name and address)			Employ	Employer (Name and address)							
	Employment Status Emplo			Employ	mployment Status							
NSII	☐ FT ☐ PT ☐ Self-Employed ☐ Student ☐ Unemployed ☐ F			d □ FT	FT 🗆 PT 🗆 Self-Employed 🗆 Student 🗆 Unemployed							
RESPONSIBLE	If unemployed, how are you surviving?			If unem	f unemployed, how are you surviving?							
~	Date last unemployment check received:				Date las	Date last unemployment check received:						
	HOUSEHOLD MEMBERS – Include Unborn Children (use a separate sheet if needed)											
	HOUSEHO	LD MEN	IBERS - In	ciuae vi	Relationship SSN Claimed on Taxes? Pregnant? Empl						Fmployed?	
0	HOUSEHC Name	LD MEN	IBERS – In DOB				SSN	Claimed	on raxes:			
INFO		LD MEM		1 1			SSN	Claimed	on raxes:	- Cognum		
OLD INFO		LD MEM		1 1			SSN	Claimed	on raxes:			
EHOLD INFO		LD MEM		1 1			SSN	Claimed	un raxes:			
OUSEHOLD INFO		LD MEM		1 1			SSN	Claimed	un raxes:			
HOUSEHOLD INFO		LD MEM		1 1			SSN	Claimed	un raxes:			
HOUSEHOLD INFO		LD MEN		1 1			SSN	Claimed	un raxes:			
HOUSEHOLD INF			DOB	Age	Relationshi		SSN	Claimed	un raxes:			
HOUSEHOLD INF	Name	r third-pa	DOB rty payer? (Age	Relationshi	ip				oup 🗆 !		
HOUSEHOLD INF	Is the patient covered by health insurance o	r third-pa	rty payer? (Age	Relationshi	ip						
HOUSEHOLD INF	Is the patient covered by health insurance o Medicare Medicaid Additional coverage or third-party payers (C	r third-pa BCBS heck all th	rty payer? (Othe	Age Check all	Relationshi	ip .		_ □ Sha	aring Gr	oup 🗆 l	Jninsured	
PATIENT COVERAGE HOUSEHOLD INFO	Is the patient covered by health insurance o Medicare Medicaid	r third-pa BCBS heck all th	rty payer? (Othe nat apply) jury	Age Check all r Insura	Relationshi	ip .		_ □ Sha	aring Gr	oup 🗆 l	Jninsured	

Revised July 2021 Page 1 of 2

		TOTAL IN	ICOME INFO	RMATION (enter monthly amounts)				
3	()	Gross Wages (before taxes)	Unemploym		Pension/Retirement			
	ונו	\$	\$		\$			
ноизеногр	NCOME (monthly)	Workers' Comp	Rental Incor	ne	Veterans Benefits			
SE	<u>.</u>	\$	\$		\$			
0	Ī	Short/Long Term Disability	Interest/Div	idends	SSI/SSDI Social Security			
ΞŞ	2	\$	\$	Ide	\$			
-	≧	Other Income \$	Alimony/Chi	• •	Carratin			
		'	۱ ۶	Case #	County			
		BAN	IKING AND C	URRENT ASSET INFORMATION				
ES		Checking Account(s)	Stocks/Bond	ls	Livestock (market value)			
K	ne	\$	\$		\$			
l g i	val	Savings Account(s)		t Cash Assistance	Property/Land (market value)			
RE	ınt	\$	\$		\$			
FAMILY RESOURCES	(present value)	IRA/CD(s)	Other Asset	(5)	Rental Property (market value)			
Ξ	(pr	Personal property (Check all that apply)	٦		\$			
₽			CL: D Town	al Tarilla a	Tabel Fating shoul Value C			
		☐ Auto ☐ Motorcycle ☐ RV ☐ Boat ☐ Jet:	SKI 🗆 Irave	er Frailer 🗀 Other	Total Estimated Value \$			
		COMPLETE THE FINANCIAL ASSISTANCE APPLICA	TION AND A	TTACH COPIES OF THE FOLLOWING.	DO NOT SEND ORIGINAL DOCUMENTS.			
5			_	ned. Please attach photocopies only				
SUPPORTING DOCUMENT		☐ Healthcare Assistance Application completed a	and signed	☐ Child support and/or alimony pa	vment records			
<u>5</u> .								
0 5	☐ Paycheck stubs or letter from employer verifyin for the three months prior to date of service ☐ Social Security/Disability benefits letter; pensio verification letter		ng income		account statements for the three months prior to			
0 0	<u> </u>	for the three months prior to date of service		date of service (logo/stamped from bank)				
Ž	☐ Social Security/Disability benefits letter; pension		☐ Most recent Unemployment Determination Letter					
\(\int \)	S	verification letter						
ک <u>و</u>		☐ Previous year's complete income tax return, including all		☐ If others help provide basic living needs, please request a "Statement of				
SCI		applicable W-2, 1099, 1098, etc.		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)				
	Please write detailed information in the space provided below describing your current financial situation and why you are unable to pay							
5	,	•		. Please be specific. Use a separate s				
TEMENT		,	.,					
Ĭ¥								
PERSONAL STA								
Z .								
SSO								
PE								
Δnv a	nnl	lication without signatures and/or the necess	ary docum	entation will not be processed up	atil information is received.			
Ally a	PP.	incution without signatures unayor the necess	ary accum	entation will not be processed an	in mornation is received.			
Ludeb +		anly for financial assistance through NIMC Health I under	tand that NINA	C Haalth avagets matiants to use all of their	ir available financial recoveres to nov their			
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.								
-		at the information I have provided above is true and comp e of determining my eligibility for financial assistance. I al		=				
-	-	ealth for the purpose of determining my eligibility for fina	-	=				
	understand NMC Health reserves the right to reverse any charity approval if substantial information was not disclosed, or information was misrepresented or							
		y withheld. In such cases, charity approvals will be reven n is found to be false or misleading, I understand my appl			ibility. If my application is incomplete or			
			20					
Applic	ant	's Signature Date		Co-Applicant's Signature	Date			
	lail i	to: NMC Health PES HCA Team PO Box 308 Nev	vton KS 671	14-0308 Drop off Monday-Eriday	82-4n (closed on holidays): NMC			

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