NMC health

PO Box 308 | Newton, KS 67114

OFFICE USE	Account #s			
	_____	Percentage	_____	
	_____	HH Size	_____	
	_____	Guideline	_____	
	_____	Date Range	_____	
	_____	Initial Acct	_____	

HEALTHCARE ASSISTANCE APPLICATION

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

PATIENT INFORMATION

Patient Last Name	Patient First Name	MI	DOB (MM/DD/YYYY)	Age	Social Security Number

Patient Address	City	ST	Zip Code

Patient Phone/Cell #	Patient Work Phone #	Patient Primary Care Physician

Is patient a citizen of the United States?	Is patient a legal/permanent resident?	Did patient file a Federal Tax Return?	Is patient/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

1st GUARANTOR	2ND GUARANTOR
Relationship to Patient ☐Self ☐Parent ☐Other _____	**Relationship to Patient** ☐Spouse ☐Parent ☐Other _____
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

FAMILY MEMBERS LIVING IN THE HOME – Include Unborn Children (use a separate sheet if needed)

Name	DOB	Age	Relationship	SSN	Claim 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 ☐ Worker's Compensation ☐ Liability ☐ Crime Victim Compensation

Expected Settlement $_____

HOUSEHOLD INCOME	INCOME INFORMATION (enter monthly amounts)		
	SSI/SSDI Social Security $	Veterans Benefits $	Pension/Retirement $
	Government Cash Assistance $	Other Income (i.e. rental income) $	
	Alimony $	Child Support $	Case #_____ County_____

FAMILY RESOURCE	CURRENT ASSET INFORMATION (enter present value)		
	IRA/401K/403B $	Stocks/Bonds/CDs $	Money Market Accounts $
	Other Asset(s) Describe_____		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	☐ Most recent Unemployment Determination letter
	☐ *U.S. Permanent Resident Card, if permanent resident (copy only)	☐ If others help provide basic living needs, please request a "Statement of Support Letter" from NMC Health to explain how they are assisting you
	☐ *Most recent **complete** Federal income tax return, including all applicable W-2, 1099, 1098, etc. or IRS Verification of Non-filing Letter	☐ Child support and/or alimony agreement as defined in a Decree of Divorce, signed by a judge and filed with the District Court Clerk, or a Certified Copy of the Divorce Decree
	☐ If your tax return includes a 1040 Schedule B, please include the most recent account statement from each of your financial service providers which lists current value(s) of your investment(s)	☐ Proof of physical address (at least two of the following: current or prior month utility, rent, or mortgage bill)
		☐ Social Security/Disability benefits letter
	☐ Government Cash Assistance benefits letter	*Must include this item. *NOTE: Other items may also be necessary.*

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 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 charges. 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, 800 Medical Center Dr, Basement Room 0017, Newton KS 67114 | **Fax:** 316.804.6280 | **Call:** 316.283.2700 ext. 1951