



FINANCIAL ASSISTANCE APPLICATION

- Olathe Medical Center, Inc.
- Miami County Medical Center, Inc.
- Olathe Health Physicians, Inc.
- Family Medicine –Paola, Louisburg, Osawatomie

**Patient Financial Engagement Services at (913)-355-8275 or
Email: financial.assistance@kumc.edu**

<u>For Office Use Only</u>		
MRN# _____	Guarantor# _____	Date Received: _____
Approved: Yes <input type="checkbox"/> No <input type="checkbox"/>		
Effective Dates: _____ to _____ Back-dated to _____		

Part A			
Patient's Full Name:	_____		
Patient's Social Security #	_____	Is patient a US Citizen?	Yes No
Patient Date of Birth:	_____		
Alternate Names Used:	_____	Permanent Resident?	Yes No

Name of Person Responsible for the Bill: _____
Relationship to Patient: _____ **Responsible Person's SSN:** _____

Responsible Person's/Patient: Address (Street, City, State, & Zip): _____

Home Phone: _____
Mobile Phone: _____
Name & Address of Employer: _____
Work Phone: _____

Occupation: _____ **Length of Employment:** _____ **Gross Wages: \$**

 Per Hour Per Month

Do you **Own?** **Rent?** **Other? If "other", describe:** _____

If you own, what is the total amount you still owe on your home? \$ _____
What is the current value of your home? \$ _____

Insurance:
 I/We have Medicare or Medicaid: Yes No If yes, list name(s) _____

I/We have other insurance: Yes No If yes, please complete the following below:

Person Insured	Insurance Company	Policy Number	Type Of Coverage

Marital Status of the Patient:
 Single Married Divorced Separated Widow

Marital Status of the Responsible Party:

Single Married Divorced Separated Widow

Spouse Employer (Name & Address): _____

Spouse's SSN: _____ **Occupation:** _____

Length of Employment: _____ **Gross Wages:** \$ _____ Per Hour Per Month

Part B – Dependents of Responsible Party (as indicated on most recent tax return):				
Full Name:	Date of birth:	Relationship:	Claimed on taxes?	
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No
			<input type="checkbox"/> Yes	<input type="checkbox"/> No

Part C	
Gross Family Income Per Month	Monthly Expenses
\$ _____ Responsible Person's Salary	\$ _____ Housing
\$ _____ Spouse or Parent's Salary	\$ _____ Utilities
\$ _____ Social Security Benefits	\$ _____ Insurance
\$ _____ Disability Benefits	\$ _____ Auto Payments
\$ _____ Welfare Assistance	\$ _____ Charge Accounts
\$ _____ Alimony or Child Support	\$ _____ Monthly Medical
\$ _____ Pension	\$ _____ Food
\$ _____ Interest Income	\$ _____ Other (describe)
\$ _____ Other (describe)	\$ _____ Other (describe)
\$ _____ TOTAL MONTHLY INCOME	\$ _____ TOTAL EXPENSES

Part D	
Responsible Person's Bank: _____	
Checking Account Balance: \$ _____	Savings Account Balance: \$ _____
Assets:	
<input type="checkbox"/> Stocks/Bonds/Certificates of Deposit	Value: \$ _____
<input type="checkbox"/> Property (describe): _____	Value: \$ _____
<input type="checkbox"/> Mortgage	Owed: \$ _____
Other Assets:	Describe: _____
<input type="checkbox"/> e.g. Autos, Life Insurance, Etc.	Value: \$ _____
_____	Value: \$ _____

Part E – The following minimum documentation MUST accompany this application for assistance. Additional information may be required, particularly when there has been a significant change in your income from one year to another.

1. Prior year Federal Income Tax Return Form (signed copy). Include schedules.
 2. Prior year W-2 Forms.
 3. Payroll check stubs for the past 2-months.
 4. Bank statements for the past 2-months.
 5. Copies of Social Security or Welfare Benefit Award Letters.
- If your application is for extended monthly payments, please indicate your Proposed Monthly Payment Amount \$ _____

Part F

