Republic County Hospital

2420 G Street • Belleville, Kansas 66935-2400 • Phone 785-527-2254

Republic County Hospital offers a Financial Assistance Program for patients who are unable to pay for Medical Care. If approved, care may be provided at no cost or at a reduced rate. Please complete the application for Financial Assistance and attach a copy of your most recent Federal Income tax return, two months of bank statements, two months of paystubs, and any additional information that you feel would be helpful to us in determining your need for financial assistance. Please include all sources of income such as child support, alimony, rental, business etc. If you have any questions, please call us at the number above.

Please return the application within the next ten (10) days to the address above. Once your application is received, your situation will be evaluated and you will be notified as to whether your application has been approved.

Thank you for allowing Republic County Hospital the opportunity to provide your healthcare needs.

Personal Financial Statement for Financial Assistance

Patient Name	Age	Phone Number	Marital Status S M W D	Social Security Number

Date Pt. Received:	Acct. # / Balance: / $	; Acct. # / Balance: / $
Please Return By:	Acct. # / Balance: / $	; Acct. # / Balance: / $
Date Returned:	Acct. # / Balance: / $	; Acct. # / Balance: / $

Patient		**Person Responsible for Bill (if not patient)**	**Relationship**
Street:		Name:	
		Street	
City, ST, Zip		City, ST Zip	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, Name of Last Employer:	If unemployed, Name of Last Employer:
How Long Unemployed?	How Long Unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes _____ No _____

If yes, why not available for this date of service? _____

If no, please indicate the reason for lack of insurance coverage? Insurance cost too high? Yes_____ No_____;
Pre-existing condition? Yes_____ No_____; Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date: _____ Reason for Denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income			
	Patient	Spouse	Other Members of Household (18 and older)
Wages (Gross)	$	$	
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List			
MONTHLY INCOME SUBTOTAL			
TOTAL INCOME:	**MONTHLY: $**		**YEARLY: $**

EXPENSES	MONTHLY	BALANCE DUE
Mortgage or Rent Payment	$	$
Car Payment		
Utilities (Gas, Electric, Water		
Cable		
Phone (Including Cell)		
Food		
Child Care		
Clothing		
Insurance (Auto, Life, Health)		
Gas/Transportation		
Recreation		
Physicians		
Hospitals		
Other Medical		
Credit Cards		
Other Expenses (Describe)		
TOTAL EXPENSES:	$	$

HOUSEHOLD ASSETS	VALUE
Savings	$
Checking	
Stocks and Bonds	
Mutual Funds, Money Marekt, etc.	
Cash Value of Life Insurance	
Real Estate Value	
Farming Real Estate Value	
Vehicles Value (not primary)	
Jewelry & Other Personal Property	
Other Assets (Describe)	
TOTAL HOUSEHOLD ASSETS:	$

HOUSEHOLD DEBTS	VALUE
Home Loan	$
Auto Loan	
Credit Card Debt	
Other: Total Expenses from "Balance Due"	
column - (Mortgage + Car Loan + Cr. Cards)	
TOTAL HOUSEHOLD DEBTS:	$

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date:

Application Determination: Approved / Denied Date Determination Letter Mailed: _____

Reason for Denial: _____

Hospital Representative Signature(s) Date: