FINANCIAL ASSISTANCE APPLICATION
Olathe Medical Center, Inc. and Miami County Medical Center, Inc.
Patient Financial Services at (913)324-8520

Mailing Address:
14425 College Blvd.,
Lenexa, KS 66215
Attention: Patient Financial Services

Physical Location:
14425 College Blvd, Ste 100
Lenexa, KS 66215

Part A

Patient's Full Name:_____
Patient's Social Security Number (SSN):_____

Name of Person Responsible for the Bill:_____
Relationship to Patient:_____ **Responsible Person's SSN:**_____
Responsible Person's Address (Street, City, State, & Zip):

Home Phone:_____

_____

Mobile Phone:_____

_____

Name & Address of Employer:_____ **Work Phone:**_____

_____
Occupation:_____ **Length of Employment:**_____ **Gross Wages: $**_____
☐ **Per Hour or** ☐ **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? $_____

Patient Address (if different than above):_____ **Home Phone:**_____
Work Phone:_____
_____ **Mobile Phone:**_____

Marital Status of the Patient: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widow**
Of the Responsible Person: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Separated** ☐ **Widow**
Patient and/or Spouse Employer (Name & Address):_____

_____
Patient or Spouse's SSN:_____ **Occupation:**_____
Length of Employment:_____ **Gross Wages: $**_____ ☐ **Per Hour or** ☐ **Per Month**

Part B - Dependents of Responsible Party (as indicated on most recent tax return):

Name	Relationship	Age

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)	_____	
$_____	TOTAL MONTHLY INCOME	$_____	TOTAL EXPENSES

Part D

Responsible Person's Bank:_____

Checking Account Balance: $_____ **Savings Account Balance: $**_____

Assets: ☐ **Stocks/Bonds/Certificates of Deposit Value: $**_____

☐ **Property (describe):**_____ **Value: $**_____

Mortagage Amount Owed: $_____

☐ **Other assets(e.g. Autos, Life Insurance, etc.) Please describe:**_____

_____ **Value: $**_____

_____ **Value: $**_____

Part E

Special situations affecting your financial status:_____

_____

_____

_____

Part F – 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 $_____

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position and give my permission to verify this information.

Signature of Responsible Party:_____ **Date:**_____