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

For Office Use Only

MRN# _____ **Guarantor#** _____ **Date Received:** _____

Approved: **Yes**☐ **No**☐ **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?	
			□ Yes	□ No
			□ Yes	□ No
			□ Yes	□ No
			□ Yes	□ No
			□ Yes	□ 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: □ **Stocks/Bonds/Certificates of Deposit** **Value**: **$** _____

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

□ **Mortgage** **Owed**: **$** _____

Other Assets: □ **e.g. Autos, Life Insurance, Etc.** **Describe**: _____

_____ **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

Please write a letter below indicating the special situation affecting your financial status. If any documents are missing for processing your application, please explain in your letter. (Please be specific)

Signature of Responsible Party:		**Date:**	

Please Return or Mail application to:
Olathe Medical Center, Inc.
Attn: Patient Access
Patient Financial Engagement Counselor
20333 W. 151st St., STE 150
Olathe, KS 66061