

## HUTCHINSON

Enclosed you will find a Financial Assistance Application.

Please complete the information requested and provide **all** documents necessary to adjudicate your application. Failure to provide all information may result in a denial for assistance.

We ask that the financial application be completed and returned within the next 30 days. The application requires your signature and complete supporting documentation provided to complete the review process.

**\*\*\*Accounts that are past 240 days from the date of discharge will not be considered for financial assistance and you will be responsible for any balances owed to ARSI or CSR.\*\*\***

We require:

1. **Complete** copy of 2015 tax return
2. 3 most recent pay stubs from employment \*\*
3. Bank Statement
4. Denial from Medicaid either through Midland Group or Department of Children and Family Services (DCFS)

\*\*If you are not currently employed, please provide verification of income. (Social Security statement, SRS letter (Food Stamps/Cash Assistance, Unemployment, etc.).

Please take time to contact the physician billing services connected with Hutchinson Regional Medical Center to notify them you are applying for Financial Assistance. These bills are your responsibility.

ER Physicians	- 844-442-7848
Radiology Professionals	- 866-815-9776
Clinical Colleagues	-866-902-4406

If you need assistance in completing this application or have questions, please call 620-665-2024.

Once the completed application and supporting documentation has been returned, please allow 30 days for processing. A letter will be sent to you with the decision.

Thank you for choosing Hutchinson Regional Medical Center for your healthcare needs.

Patient Accounts  
620-665-2024 Phone  
620-513-3826 Fax



**HUTCHINSON**  
REGIONAL MEDICAL CENTER

*This information obtained will be kept confidential and used only for Financial Assistance determination.*

Financial Assistance Application Form "A"

Patient Name: \_\_\_\_\_ Patient Account #(s) \_\_\_\_\_  
 Responsible Party Name (if patient is a minor): \_\_\_\_\_ SS# \_\_\_\_\_  
 Spouse's Name: \_\_\_\_\_ SS# \_\_\_\_\_  
 Physical Address: \_\_\_\_\_ SS# \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 \_\_\_\_\_

Number of family members living in the home (spouse and dependents): \_\_\_\_\_  
 Have you recently made, or plan to make an application for Medicaid and/or Medical Assistance? Yes No  
 \_\_\_\_\_ Date of Application: \_\_\_\_\_

**INCOME VERIFICATION (List all persons in household who are employed)**

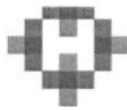
Name	Relationship to Patient	Employer's Name & Address	Monthly Income	
			Gross	Net
			\$	\$
			\$	\$
			\$	\$
			\$	\$

**OTHER INCOME (List monthly accounts)**

Name	Relationship to Patient	Child Support	Unempl. Comp.	TANF	Social Security	SSI	VA	Interest Income
		\$	\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$	\$
		\$	\$	\$	\$	\$	\$	\$

**RESOURCES (List all resources owned by members of the household and value)**

Resource	Bank or Company	Value	Owner
Checking Account			
Savings Account			
Certificates of Deposit			
Trust Fund			
Stocks or Bonds			
Retirement Account			
Other			
Mutual Funds			



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## Financial Assistance Application Form "B"

Name: \_\_\_\_\_

MONTHLY EXPENSES	MONTHLY PAYMENTS	CURRENT BALANCE
Food	_____	_____
Rent/House Payment	_____	_____
Gas - House	_____	_____
Electricity	_____	_____
Water and Sewer	_____	_____
Cable Television/Satellite	_____	_____
Telephone (including wireless)	_____	_____
Gas (Car)/Transportation	_____	_____
Car Payment	_____	_____
Car/House Insurance	_____	_____
Health/life Insurance	_____	_____
Prescriptions	_____	_____
Doctors/Healthcare Providers	_____	_____
Credit Cards•	_____	_____
Other•	_____	_____

Total Monthly Income \_\_\_\_\_

Total Monthly Expenses: \_\_\_\_\_

Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Example of additional supporting documents:

1. The latest available W-2 forms of all family members contributing to the household income.
2. Most recent six (3) pay stubs of all the family members contributing to the household income.
3. Prior year household income tax return.
4. Forms approving or denying unemployment compensation.
5. Written verification from employer(s) of current wages.
6. Written verification from public welfare agencies which attest to the income level for the past 12 months.
7. Medicaid remittance voucher indicating benefits for a claim in question or that benefits have been exhausted.
8. Asset search revealing no estate or assets.

•Please list on separate sheet of paper.