HUTCHINSON
REGIONAL MEDICAL CENTER

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 2016 tax return
2. 3 most recent pay stubs from employment **
3. Bank Statement

**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

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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: _____