HUTCHINSON
REGIONAL MEDICAL CENTER

Thank you for choosing Hutchinson Regional medical center for your healthcare needs. 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 require:

1. Complete copy of current year's tax return
2. Three (3) most recent pay stubs from employment
3. Complete bank statement of the past 30 days of activity

**If you are not currently employed, please provide verification of income. (Social Security determination letter, Kansas Dept of Labor unemployment compensation, DCF letter proving qualification for the following: Food Stamps, Cash Assistance).

We ask that the financial assistance application be completed and returned within 15 days of the date stamp on this letter. **The application requires your signature and complete supporting documentation to complete the review process.** The timely completion of this application may impact the status of your accounts(s). The processing of this application **does not** relinquish you from your financial obligation related to your account(s) once the application is processed.

*** Accounts that are past 120 days from the date of discharge will not be considered for financial assistance and you will be responsible for any balances owed to the collection agency. ***

If you need assistance in completing this application or have questions, please call 620-665-2024 to speak with one of our Financial Counselors.

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
Hawthorne Radiology	- 314-821-8055 opt 3
Meridian Anesthesia	- 866-575-9644

Once **the completed** application and ALL supporting documentation has been returned, it may take up to 30 days to process. **PLEASE do not call** to inquire of the status within the first 30 days of the processing of you completed application as this may delay the review process.

Adhering to the steps outline in this cover letter will aid the Financial Review team in the completion process. We thank you in advance for your consideration in this matter.

Hutchinson Regional Medical Center
Patient Accounts Department

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			

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

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: _____