NEOSHO MEMORIAL
REGIONAL MEDICAL CENTER

Dear Patient:

Neosho Memorial Regional Medical Center and its joint facilities have a Financial Assistance Program for patients who may need assistance paying for their medical care. Eligibility for the program is based on your family's income and the number of individuals in your household.

In order to be considered for assistance, please complete the attached application form and send in all information requested. If you are unable to complete the forms, you may have an authorized representative you have selected complete it for you.

Please send your completed application and **ALL** supporting documentation listed in the application packet after your insurance company has made final payment on all accounts you wish to have considered for Financial Assistance.

Neosho Memorial Regional Medical Center
Patient Financial Services
PO Box 426
Chanute, KS 66720

We will notify you in writing when your application is either approved or denied.

If you have any questions regarding the application or process, please call me (620) 432-5324.

You are eligible for emergency medical care even if you are unable to pay for services.

PLEASE NOTE: WE ONLY ACCEPT COPIES OF REQUIRED / REQUESTED DOCUMENTS. PLEASE DO NOT SUBMIT ORIGINALS AS WE CANNOT MAKE COPIES.

Your application must be completed in its entirety and returned with ALL information requested in order to be considered for the Financial Assistance program. Failure to do so will result in a denial of your application.

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PLEASE UTILIZE AND RETURN THIS CHECKLIST TO ENSURE ALL REQUESTED ITEMS ARE ACCOUNTED FOR

☐ Income tax returns for most recent year (**MUST be a full copy of all pages of the 1040; we cannot accept summaries. MUST also include all supporting schedules and attachments**) - (if none, please explain:) _____

☐ Last **2 months** of income documentation (including regular payroll, retirement, pension, commissions, bonuses, farm, sales, or any other income you receive)

☐ Official Unemployment letter/statement (if applicable)

☐ Official Social Security and/or Social Security Disability Benefit **award letter** for the **CURRENT YEAR** (if applicable).

☐ Documentation of Child Support received (if applicable). You can obtain this information from the KPC website. Please provide us with a printout.

☐ Attached letter explaining your situation and need for Financial Assistance must be Completed.

☐ Attached Monthly Financial Report must be completed in its entirety – Please write N/A in boxes if items are non-applicable

☐ Application completed in its entirety and ***signed by all responsible parties. SPOUSE MUST SIGN ALSO, IF YOU ARE MARRIED.***

Explanation Letter for Financial Assistance

Signature **Date**

Signature **Date**

Financial Assistance Program Application Form

If you have any questions about this application, contact the Patient Accounts Representative at (620) 432-5324.

Please do not leave any boxes or questions blank. If a section or question is not applicable to you, write N/A next the item. Thank you.

1. Applicant Information:

Last Name First Name MI	Financial Assistance Sequential Control Number (For Hospital use only)
Street Address	Telephone Numbers: Home _____ Work _____ Cell _____
City State Zip Code	Mailing Address (if different from Street Address)
Date of Birth	Male___ Female___

2. If you are applying for someone else, complete this section:

Last Name First Name MI	Relationship to Applicant:
Street Address	Telephone Numbers: Home _____ Work _____ Cell _____
City State Zip Code	Mailing Address (if different from Street Address)

3. Family Information: List the people that live with you. Include your spouse, dependent children under age 18, and anyone else that shares a home with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___
			M ___ F ___	Y ___ N ___

4. Please answer all the questions below:

	Y	N		Y	N
Are you Homeless?			**Are you Unemployed?**		
Are you Uninsured?			**Are you Insured? If yes, please provide insurance information below: _____**		
Are you Divorced?			**Are you Legally Married?**		
Are you Widowed?			**Are you Disabled?**		
Are you Pregnant?			**Are you 17 years old or younger?**		
Are you a Student? Full-time or Part-time_____			**Are you 65 years old or older?**		
Are you uninsured and have a pre-existing condition?			**Have you recently lost insurance due to loss of employment?**		
Do you have an application for health insurance pending with Medicaid?			**Do you have an application for health insurance pending with Medicare?**		
Have you recently been denied Medicaid? If yes, please provide letter reflecting denial.			**Have you recently been denied Medicare? If yes, please provide letter reflecting denial.**		
Was the medical care you received and are requesting FAP for due to injuries received as a crime victim?			**Have you been unemployed for 1 year or over and have a medical or psychological condition?**		
Are you seeking Financial Assistance due to a work related injury?			**Are you seeking Financial Assistance due to an accident? If yes, has insurance been filed?_____**		
Are you an undocumented worker that had a medical emergency?			**Do you have a diagnosis of Tuberculosis?**		
Have you been diagnosed with Breast or Cervical Cancer through an "Early Detection Works" Clinic or facility?			**Do one or more persons share their income or assets in any way to assist you with your financial and or physical support?**		
For any reason, was it necessary for you to allow your Affordable Healthcare Marketplace Insurance to lapse? If yes, when was the last date you made a payment?					

5. Sources of Income:

Employer Name & Address	Family Member Receiving Income	**GROSS** Amount	How Often? Weekly/Monthly/Annually
Child Support			
Alimony			
Social Security			
Social Security (Co-Applicant)			
Retirement or Pension Funds			
Veteran's Benefits			
Gas/Oil Royalties			
Unemployment			
Worker's Comp			
Rental Income			
Trust Income			
County General Relief			
Annuities			
Dividend Income			
Bank Account Income			
Commissions			
Bonus			
Personal Allowance			
Other Income			
Other Income			

6. Assignment of Rights: (*Read this section carefully and sign)*

I agree to tell this Medical Center about changes to my family status including family size, income, and insurance coverage that could change my eligibility for Financial Assistance. I understand that failure to do so will result in denial of my application. All information in this application is true to the best of my knowledge. I agree to provide documentation upon request. **I understand that this Medical Center cannot share confidential information without my prior approval.**

All responsible parties for hospital charges need to sign application below.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Spouse or Co-applicant Date

RELEASE OF INFORMATION: I hereby authorize NMRMC to disclose or obtain information regarding my FAP application to the below named persons.

Name: Relationship:

1. _____
2. _____

MONTHLY FINANCIAL REPORT

Assets	**Amount**	**Monthly Income**	**Amount**	**Medical Creditors**	**Monthly Payment**	**Unpaid Balance**	Rent_____Own_____	$
Savings Account	$	Gross Pay – Income #1	$	Hospital	$	$	Utilities (Total Electric, Gas, Water, Trash and any other)	$
Checking Accounts	$	Gross Pay – Income #2	$	Hospital	$	$	Phone (Total Cell and Home Phones)	$
Stocks-Bonds IRA/ 401K/ CD	$	Commissions – Income #1	$	Physician	$	$	TV/Internet (Total)	$
Autos		Commissions – Income #2	$	Physician	$	$	Food	$
Make Year		Bonus – Income #1	$	Physician	$	$	Childcare	$
Make Year		Bonus – Income #2	$	Imaging (Diagnostics)	$	$	Homeowners Insurance Property Taxes (if not included with mortgage payment)	$
Home (if purchasing or own)		Dividends – Interest	$	Anesthesia	$	$	Life Insurance Auto Insurance	$ $
Year Home Purchased		Food Stamps	$	Ambulance	$	$	Alimony/Child Support	$
Estimated Value of Home		Unemployment	$	Helicopter	$	$	Auto Maintenance Auto Payment Gas	$
Other Real Estate		Public Assistance (Cash)	$	Dentist	$	$	Credit Cards (Usual monthly payment)	$
Description, location, & estimated value of other Real Estate:		Child Support and/or Alimony	$	Pharmacy	$	$	Other loans	$
		Other Income (please specify)	$	DME	$	$	Student Loans (Monthly Total)	$
Other Assets (Boat, RV, Motorcycle, etc	$	Other Income	$	Therapy	$	$	Car Payment	$
		TOTAL MONTHLY INCOME		Other			Boat, RV, Motorcycle, Other Payment	$

Revised: 08/2018; Reviewed 11/2024