ATCHISON HOSPITAL
FINANCIAL ASSISTANCE APPLICATION & DETERMINATION

Please note: A complete financial assistance application (including all required documentation) must be received at Atchison Hospital **within 240 days from the date of your first statement** to be eligible.

I. IDENTIFYING INFORMATION:

Members of household including yourself, spouse, significant other, dependents, full-time students, others:

	Name	Relationship	Date of Birth	Sex
Responsible Party (Self)		SELF		
Spouse or Significant Other				
Dependant 1				
Dependant 2				
Dependant 3				
Dependant 4				
Dependant 5				

*Please continue on the back of this application if you have more than 5 Dependants.

Maiden name or any other name known by:

Self: _____ Spouse: _____

Applicant Social Security Number: _____-_____-_____

Street Address	City	County	State	Zip Code

Mailing Address (if different from above):	Telephone Number(s):
	Home:
	Work:
	Cell or Other:

Why are you requesting Financial Assistance?

- **PLEASE ATTACH LETTER OF EXPLANATION**

Have you applied for Medicaid (Title XIX)? ☐ Yes ☐ No

- **IF YES, PLEASE PROVIDE A COPY OF YOUR DHS NOTICE OF DECISION.**

If you have dependents <19 years old, have you applied for Medicaid? ☐ Yes ☐ No

Have you applied for Disability? ☐ Yes ☐ No

Have you applied for SSI (Supplemental Security Income)? ☐ Yes ☐ No

Veteran Status: ☐ Yes ☐ No If yes, date of service _____

II. INCOME

Does anyone in your household have any of the following resources? Check "yes" or "no" for each item. Complete columns C & D and provide required documentation as indicated in Column E for items checked "yes".

MONTHLY

A	B	C	D	E
Source of Income	**Check One**	**Amount**	**How often is income received?**	**Provide Required Documentation**
FIP-Family Investment Program	☐ Yes ☐ No	$		
Self Employment	☐ Yes ☐ No	$		Federal Income Tax Return
Employment:		$		Last 3 months pay stubs
Self – Primary Job	☐ Yes ☐ No	$		Last 3 months pay stubs
Self – Secondary Job	☐ Yes ☐ No	$		Last 3 months pay stubs
Spouse – Primary Job	☐ Yes ☐ No	$		Last 3 months pay stubs
Spouse – Secondary Job	☐ Yes ☐ No	$		Last 3 months pay stubs
Other	☐ Yes ☐ No	$		Last 3 months pay stubs
Unemployment, Worker's Compensation	☐ Yes ☐ No	$		Weekly Proof of Benefit Amount
Social Security	☐ Yes ☐ No	$		Supporting Documentation
Railroad Retirement	☐ Yes ☐ No	$		Supporting Documentation
Supplemental Security Income (SSI)	☐ Yes ☐ No	$		Supporting Documentation
Veterans Benefits	☐ Yes ☐ No	$		
Child Support-Alimony	☐ Yes ☐ No	$		Documentation of payments received
Military Dependency Allotment/Allowance	☐ Yes ☐ No	$		
Disability Insurance Payments	☐ Yes ☐ No	$		
Other Pension or Compensation	☐ Yes ☐ No	$		
Money from other persons, gifts	☐ Yes ☐ No	$		
Money from interest dividends	☐ Yes ☐ No	$		
Room and/or Board Income	☐ Yes ☐ No	$		
Commissions or other lump sum payments	☐ Yes ☐ No	$		
Health Policies paying you income	☐ Yes ☐ No	$		
Other (Explain)	☐ Yes ☐ No	$		

- Unemployed? ☐ Yes ☐ No If you or your spouse is working, please fill out the below chart.

CURRENT EMPLOYMENT OF SELF, SPOUSE & OTHER (if applicable):

Person	Employer	Date Began	Date Ended	Monthly Wages	Reason for Leaving
Self: Primary Job				$	
Self: Secondary Job				$	
Spouse: Primary Job				$	
Spouse: Secondary Job				$	
Other				$	

III. HEALTH INSURANCE

A	B	C
Policy	**Check One**	**Comments**
Do you have Medicaid (Title 19)?	☐ Yes ☐ No	Provide copies of all family members' cards.
If No, have you applied for Medicaid?	☐ Yes ☐ No	**If you have applied for Medicaid, please <u>provide a copy of your DHS Notice of Decision</u>.**
Were you approved?	☐ Yes ☐ No	
If yes, do you have a spendown?	☐ Yes ☐ No	
What is your spendown amount?	$_____	
Do you have Medicare?	☐ Yes ☐ No	If yes, fill in Insurance information below.
If No, have you applied for Medicare?	☐ Yes ☐ No	If yes, date applied: _____
Other	☐ Yes ☐ No	If yes, fill in Insurance information below.

Insurance Name: _____ ID#: _____
Policy Holder Name: _____
Names of covered family members: _____
_____

Insurance Name: _____ ID#: _____
Policy Holder Name: _____
Names of covered family members: _____
_____

Insurance Name: _____ ID#: _____
Policy Holder Name: _____
Names of covered family members: _____
_____

- **Please provide copies of CURRENT Insurance Cards and indicate covered family members.**

IV. RESOURCES

Does anyone in your household have any of the following resources? Check "yes" or "no" for each item. Complete the information line for items checked "yes."

		Amount	Location	Name(s) of Person	Provide Required Documentation
Cash	☐ Yes ☐ No	$			
Checking Account	☐ Yes ☐ No	$			Most recent past 3 months
Savings Account	☐ Yes ☐ No	$			Most recent past 3 months
Stocks/Bonds	☐ Yes ☐ No	$			
Time Certificates	☐ Yes ☐ No	$			
Conservatorship/Trust	☐ Yes ☐ No	$			
Safety Deposit Box	☐ Yes ☐ No	$			
Other	☐ Yes ☐ No	$			

CERTIFICATION STATEMENT

Note: Please read carefully before signing

I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand that Atchison Hospital will use these statements to determine my eligibility for the Financial Assistance Program. If any information changes, it is my responsibility to contact Atchison Hospital to report such changes. I further understand that any false representations or false claims, statements, or documents or concealment of a material fact may result in the immediate termination of any financial assistance granted to me or my family and that I will be liable to repay all amounts of financial assistance previously provided to me.

I understand that Atchison Hospital may contact other agencies including the Department of Human Services to confirm statements made in this application and to obtain information that may be necessary to establish my eligibility for the Financial Assistance Program. My signature below shall authorize such mutual exchange of information between Atchison Hospital and appropriate agencies or persons.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. **(Each adult listed on this application must sign)**

_____ _____

Signature of Applicant (or legal guardian) Date

_____ _____

Signature of Spouse or Significant Other (if applicable) Date

PROHIBITION AGAINST DISCRIMINATION

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

RIGHT OF APPEAL

If you are not satisfied with the action of this office, you may appeal to the Chief Executive Officer of Atchison Hospital
Address: 800 Raven Hill Dr., Atchison, KS 66002 Telephone: (913) 367-2131, ext. 5586

Please provide the following items (if applicable) in order for your application to be processed:

- ☐ **Copy of your DHS Notice of Decision for Medicaid (Title 19)**
- ☐ **Most recent Federal Income Tax Return**
- ☐ **Copies of proof of income (i.e. paycheck stubs) for the most recent past 3 months**
- ☐ **Copies of bank statements (i.e. checking/savings) for the most recent past 3 months**
- ☐ **Copies of all other unpaid outstanding medical debt (i.e. other hospitals/clinics)**
- ☐ **Copies of Insurance Cards (Please indicate names of covered family members)**
- ☐ **Letter of explanation of your current situation**
- ☐ **Proof of student status**

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Revised: 12-2017