Financial Assistance Application

Patient's Name _____ Social Security # _____
Last First MI
Date of Birth____/ ____/ ____ Sex___ Male(M) or Female (F) Are you a U.S. Citizen? Yes or No
Marital Status: _____

Address _____
Street City State Zip

Phone Number _____

Employer Name_____ Employer Address_____

Employer Phone Number_____

Spouse's Name _____ **Spouse's** SS# _____

Spouse's Employment: _____

How many are in your household? (Include yourself) Adults _____ Minors _____ Total _____

Name	Relationship	Age

Income Detail

(** Please provide photocopies of checks or current pay stubs)

	Monthly $	Annual $
Wages (Self)	_____	_____
Spouse	_____	_____
(Other Family Member)	_____	_____
Farm or Self-Employment	_____	_____
Public Assistance	_____	
Social Security	_____	
Unemployment Compensation	_____	_____
Child Support/Alimony	_____	_____
Pensions,Military,Dividends,etc	_____	_____

Expense Detail (Monthly)

Mortgage/ Rent* (circle one) _____Do you Own or Rent (circle one)… Value of home: $_____
*If renting, a letter from your landlord is required

Home Insurance / Taxes _____
Utilities:*Cable/ Satellite _____
*Electricity _____
*Water _____
*Gas or Propane _____
Telephone _____
Cell Phone _____
Food _____
Finance Companies _____
Auto Loans & Insurance _____
Medical Insurance _____
Medical Bills: List all Medical Facilities: monthly pays: balance on acct:

_____	$ _____	balance $ _____
_____	$ _____	balance $ _____
_____	$ _____	balance $ _____
_____	$ _____	balance $ _____
_____	$ _____	balance $ _____

Medical Total: $ _____

Rx Total: $_____

Child Care _____
*Other Additional Expenses _____ _____

TOTAL EXPENSES **$_____**

Do you own other real property? Yes ( ) No ( ) If yes, estimated value of each _____
Do you own personal property such as:
*Boats $_____
*Campers (Winnebago, bus, etc.)$_____
*Other recreational vehicles $_____
Do you own automobiles? Yes ( ) No ( ) If yes, Model/Make_____
Year_____
Value_____
Lien Holder_____

By my signature I verify that the information within this application is true and correct to the best of my knowledge. Coffeyville Regional Medical Center may verify the information above by credit reports, employer inquires, or other standard credit checks. A state Medicaid application is required to complete this application for financial assistance from CRMC Inc., therefore by my signature I authorize the release of any information needed to complete that process, including copies of notices from SRS. Falsification of information may result in denial of financial assistance and recovery of amount owed through collection action.

***** A COMPLETED MEDICAID APPLICATION IS REQUIRED OR AN ADEQUATE FINANCIAL SCREENING FOR FINANCIAL ASSISTANCE TO BE CONSIDERED.**

Signature:_____ **Date**: _____

Patient's Comments: In your own words, explain why you are asking for financial assistance at this time and why you came to CRMC to seek medical attention. Also include your medical situation and any information that would be important to our Board of Directors in determining the outcome of your assistance.

At the time of your appointment please have the following in hand.

1. Proof of Income (Paycheck Stub or Employer's Letter)
2. Copies of the current statements for the following: (checking/savings, medical bills)
3. Last federal income tax return
4. Personal property and real property assessment
5. Letter addressed to Coffeyville Regional Medical Center's Board of Directors explaining your financial situation. This form is located above.
6. Complete screening from SRS or SSI stating eligibility.

**** Failure to provide any of the above information will be cause for denial****

Mail to:

Coffeyville Regional Medical Center

Financial Assistant Services

1400 W. 4th
Coffeyville, KS 67337

Revised 12-2008