

Coffeyville Regional Medical Center Financial Assistance Program

Dear Patient,

Coffeyville Regional Medical Center (CRMC) strives to meet the medical needs of our patients in a manner consistent with our Mission, Vision, and Core Values. We are committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay for medically necessary care based on their financial situation.

Please submit any/all documents that apply to your current financial situation from the list below so that we can determine if you qualify for a financial assistance discount:

1. **Completed Financial Assistance Application (attached)**
2. **Copy of Denial/Approval Letter from KanCare optional online**
<https://cssp.kees.ks.gov/apsspssp/>
3. **Copy of Foodstamp Letter**
4. **Copy of SSDI Award Letter**
5. **Copy of last two months of income verification**
6. **Copy of last two months of all bank account statements**
7. **Copy of most recent income tax statement**
8. **Letter explaining current need of financial assistance**

Should any item be missing or the application incomplete, the application will be denied. You will receive a phone call and/or letter advising you of the denial and how to appeal. If supporting documentation is not provided within **ten (10) business days** of notification, CRMC will proceed with our normal collections process, which could include extraordinary collection actions (ECA). ECA are defined as those requiring a legal or judicial process, involve selling a debt to another party or reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process for this purpose include 1) a lien; 2) foreclosure on real property; 3) attachment or seizure of a bank account or other personal property; 4) commencement of a civil action against an individual; 5) actions that cause an individual's arrest; 6) actions that cause an individual to be subject to body attachment; and 7) wage garnishment.

**Please mail above items to:
Coffeyville Regional Medical Center
Financial Assistance Program
1400 W 4th St
Coffeyville, KS 67337**



Financial Assistance Checklist

Only Copies Accepted - **Do NOT send originals.** Please use and return this checklist to ensure all requested items are included.

- Income tax returns for most recent year. If none, please explain:

- Statements for all bank accounts for the **last two (2) months** - checking, savings, etc. VERY IMPORTANT - if a deposit to your bank statement is not payroll related, please write the source of funds next to the deposit. If you do not have any bank accounts, please state so:

- **Last two (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 retirement and/or Social Security disability benefit award letter for the **current year** (if applicable).
- DCF denial letter – applicable only to applicants that are under the age of 19, pregnant, disabled or over the age of 65.
- Proof of eligibility for Food Stamps, WIC and/or TANF (if applicable)
- Documentation of child support received (if applicable). You can obtain this information from the KPC website.
- **Letter explaining your situation** and need for financial assistance must be completed and returned (located on page two of application).
- **Attached Monthly Financial Report in its entirety must be completed. Please write n/a in boxes if items do not apply to you.**
- Application must be completed in its entirety and **signed by all responsible parties.**
- Please call our Financial Counselor at 620-252-1549 for any questions or concerns. They are available Monday – Friday 8am to 4:30pm.



Coffeyville Regional Medical Center Financial Assistance Program Application Form

If you have any questions about this application, contact the Patient Accounts Representative at (620) 252-1549.

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			Home number Work number Cell number
City	St	Zip	Mailing address (if different from street address)
Date of Birth			Sex – Male or Female
Social Security #			Are you a US Citizen? Yes or No If No, are a Permanent Resident?

2. Applicant Spouse:

Last name	First name	MI	Relationship to Applicant
Street address			Home number Work number Cell number
City	St	Zip	Mailing address (if different from street address)

3. Family information: List ALL people in your household that live with you and that you support or you are supported by. (attach another sheet for any additional members if needed)

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



4. Please answer all the questions below:

	Y	N		Y	N
Are you homeless?			Are you unemployed?		
Do you have insurance? If yes, provide insurance information:			Were you in foster care at the age of 18 and are currently under the age of 26?		
Are you divorced?			Are you married?		
Are you widowed?			Are you disabled?		
Are you pregnant?			Are you 17 years old or younger?		
Are you a student? Full or part time?			Are you 65 years old or older?		
Do you have an application pending with Medicaid?			Have you recently been denied Medicaid? If yes, please provide denial letter.		
Have you been unemployed for 1 year or over and have a medical or psychological condition?			Was the care you received due to injuries received as a crime victim?		
Was the care you received due to a work related injury?			Was the care you received due to an accident? If yes, has it been filed with insurance?		
Was the care you received due to a motor vehicle accident? If yes, has it been filed with insurance?					

5. Presumptive eligibility:

Patients are presumptively eligible for financial assistance if one of the following categories applies.

Please mark any applicable categories:

- _____ Patient is homeless or receiving care from a homeless clinic (please submit proof if applicable)
- _____ Patient is deceased with no estate or surviving spouse (we may request death certificate if necessary)
- _____ Patient is now eligible for Medicaid, but was not on the date of service or for non-covered and spend down services
- _____ Participation in Women, Infants and Children (WIC) programs (please submit proof of eligibility)
- _____ Food stamp and/or cash assistance (TANF) eligibility (please submit proof of eligibility)
- _____ Low income/subsidized housing (please submit proof of eligibility)



6a. Income Verification:

Income Source: 100%	Person Receiving Income	Gross Amount
Employer or Social Security		
Employer or Social Security		
Unemployment		
Workers Compensation		
Child Support / Alimony		
Veteran's Benefits		
Rental Income		
Gas/Oil Royalties		
Dividend or Trust Income		
Commissions/Bonuses		
Other		
Total Income		

6b. Asset Verification:

Assets Source: 25 %	Person Receiving Income	Gross Amount	Multiplied at	Income Eligible Amount
Cash/Checking/Savings			25%	
Retirement or Pension Accounts			25%	
Certificate of Deposits			25%	
Stocks or Bonds			25%	
Other Securities			25%	
Equity of Real Property	(Excluding Primary Residence)		25%	
Equity of Motor Vehicles	(Excluding One Vehicle)		25%	
Other			25%	
Total Assets				

Total Income \$ _____ + Total Assets \$ _____ = Total Source of Income \$ _____

7. Expense detail:

Rent/Mortgage		\$	
Home Insurances/Taxes		\$	
Utilities:		\$	
Electric		\$	
Water		\$	
Gas or Propane		\$	
Phone:		\$	
Home		\$	
Cellular		\$	

9. Certification:

I certify that the information I have provided in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by CRMC. I authorize CRMC to contact third parties to verify the accuracy of the information I have provided. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the full hospital bill. I also agree to tell CRMC about any changes to my family status including family size, income and insurance coverage that could change my eligibility for financial assistance. **I understand that CRMC cannot share confidential information without my prior approval.**

Signature of Applicant

Date

Signature of Co-Applicant

Date

RELEASE OF INFORMATION: I hereby authorize CRMC to disclose or obtain information regarding my financial assistance application to the below named persons:

Name:

Relationship:

1. _____

2. _____

