Dear Patient,

Rawlins County Health Center's policy offers financial assistance to those patients who are uninsured or underinsured and have a household income of 300% or more below poverty level. If you believe you would qualify for these benefits or are having difficulty paying your current medical bills, please take the time to fill out this application. When submitting your application please remember to include all of the following documents to support your financial situation. Household assets do not need to be included for outpatient or ER services. Your application will be reviewed and you will be notified of the decision within 30 days of our receipt of a complete application.

Documents needed for Financial Assistance approval:

1. Individual or family income tax returns (include earnings statements, W-2s, 1099s, etc. for the past two years)
2. Payroll stubs, Social Security checks or unemployment checks from the last 90 days
3. In the absence of income, a letter of support from individuals providing for the patient's basic living needs
4. Documentation of employment status
5. Denial letter from Medicaid

If you need assistance with this application, please contact the Accounts Receivable department at 785-626-3211, Ext. 203.

Sincerely,

Bailey Philpott
Financial Services Assistant

Personal Financial Statement for Financial Assistance

Patient Name:	Age	Phone Number (_____)-_____-_____	Marital Status S M W D	Social Security Number _____ - _____ - _____

Date Pt. Received:	**Acct #:**	**Balance:$**
Please Return By:	**Acct #:**	**Balance:$**
Date Returned:	**Acct #:**	**Balance:$**

Patient	Person Responsible for Bill (if not patient)	Relationship
Street:	**Name:**	
City, ST, Zip	**City, ST, Zip**	
Phone: (____)-____-_____ **Cell:** (____)-____- Phone:	**Phone:** (____)-____-_____ **Cell:** (____)-_____-_____	

EMPLOYMENT

Patient's Employer:	**Guarantor's Employer:**
Occupation:	**Occupation:**
If unemployed, Name of Last Employer:	**If unemployed, Name of Last Employer:**
How Long Unemployed?	**How Long Unemployed?**

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes_____ No_____

If yes, why not available for this date of service? _____

If no, please indicate the reason or lack of insurance coverage. Insurance cost too high? Yes_____ No_____

Pre-existing condition? Yes_____ No_____ Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date applied: _____

If denied, date: _____ Reason for denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income				
	Patient	**Spouse**	**Other Members of Household (18 and older)**	
Wages (Gross)	$	$		
Social Security				
Pensions				
Unemployment/Work Comp				
Alimony/Child Support				
Government Assistance				
Disability Payments				
Dividends/Interest				
Other, List				
MONTHLY INCOME				
TOTAL INCOME:	**MONTHLY: $**		**YEARLY:**	

EXPENSES **(not for outpatient or ER service)**	**MONTHLY**	**BALANCE DUE**	**HOUSEHOLD ASSETS** **(not for outpatient or ER services)**	**VALUE**
Mortgage or Rent Payment	$	$	Savings	$
Car Payment			Checking	
Utilities (Gas, Electric, Water			Stocks and Bonds	
Cable			Mutual Funds, Money Marekt, etc.	
Phone (Including Cell)			Cash Value of Life Insurance	
Food			Real Estate Value	
Child Care			Farming Real Estate Value	
Clothing			Vehicles Value (not primary)	
Insurance (Auto, Life, Health)			Jewelry & Other Personal Property	
Gas/Transportation			Other Assets (Describe)	
Recreation				
Physicians				
Hospitals				
Other Medical				
Credit Cards				
Other Expenses (Describe)				
			TOTAL HOUSEHOLD ASSETS:	**$**
			HOUSEHOLD DEBTS	**VALUE**
			Home Loan	$
			Auto Loan	
			Credit Card Debt	
			Other: Total Expenses from "Balance Due"	
			column - (Mortgage + Car Loan + Cr, Cards)	
TOTAL EXPENSES:	**$**	**$**	**TOTAL HOUSEHOLD DEBTS:**	**$**

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date:

Application Determination: Approved / Denied Date Determination Letter Mailed:

Reason for denial: _____

Hospital Representative Signature (s) Date: