

## EXCELSIOR SPRINGS HOSPITAL 1700 RAINBOW BLVD. EXCELSIOR SPRINGS, MO. 64024 (816) 629-2798

As part of Excelsior Springs Hospital's on-going commitment to our community, we offer discounts through our Financial Assistance Policy, established to help persons with no insurance or those who cannot afford to pay their medical bills after insurance has paid. Eligibility is determined by family size, income, assets, and residency in one of the following zip codes: 64024, 64060, 64062, 64671, 64077, 64084, and 64073, and/or patients of local primary care Medical Staff members.

Enclosed you will find an application for assistance; if you wish to apply, please return the completed form to the hospital Business Office, along with the following:

- Proof of residency—for example, a copy of a utility bill, credit card bill, etc.
   Personal correspondence (i.e. letter from a friend) is not acceptable.
- 2. Copy of 4 recent pay stubs for each person in the household with any type of income. W-2's are not acceptable as proof of income. If self-employed, please submit a complete copy of your current income tax return.
- 3. Copy of proof of any other income the household receives social security, pension, food stamps, child support, etc. Also please include a copy of your most recent bank statement.
- 4. You will be required to apply for assistance with Medicaid if we believe you qualify for benefits. The letter approving or denying your application will be needed with your application for assistance.

Please return the application and requested information to us within ten (10) days, so that a determination of eligibility can be made.

If you have any questions concerning this program or your account, please call (816) 629-2798.

Sincerely, Patient Accounts Excelsior Springs Hospital

## Financial Assistance Application Part A- Patient Information

Last Name	Firs	t Name	Birthda	ateSSN	
Address Home Phone Marital Status: Single			City	State	Zip
Home Phone	Cell F	hoпе	Work Ph	ione	····
Marital Status: Single	Live-In	Partner Marrie	d Separated	Divorced W	idowed
Do any of your dependents	have ar	v accounts that ne	ed to be conside	ered with this applica	ation?
Vec No					
Please list all account num	bers, inc	luding any applica	bie dependent a	ecounts:	
Account Name	,		Account Num	ber	
Account Ivanic					
	1				
Part B- Responsible	Party I	nformation			
Examples include: spouse,	live-in I	partner parent, gua	ardian, guaranto	r, etc.	
If same as patient, skip I Last Name Address	artb	First Name		Relationship to Pation	ent
Last Name			City	State	_Zip
Address					
B (C December					
Part C- Dependents List all dependents who re		licent's hom	e for whom the	annlicant takes fina	ncial
List all dependents who re- responsibility. Check the a	side in u	te applicant 5 nom	o for each dener	dent. Attach an ad	ditional sheet if
	ppropris	tte retationstup oox	C 101 Cabii dopoi	IMOING INDIANA	
necessary.		C	Doront	Child (under 21)	Other
Name	Age	Spouse/partner	Tarent	CHIA (MANA 22)	
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				01 !- 4 - 1	
Number of people in hous	ehold	Number of o	children under a	ige 21 in the nome_	
Part D- Household In	come	& Assets			
LIST BELOW THE INC	OME	OF ALL HOUSE	HOLD MEMB	ERS	
Wages Vear	14	our (Ple	ase attach 4 cur	rent check studs)	·
Farm/Self Employed		(Please attac	h complete curr	ent tax return)	
Public Assistance		Chi	ld Support		
Food Stamps		7. 7.11	itary Allotment		
Social Security					
			idend interest	rent	
Unemployment					
Workman's Compensation		0.1			
Housing Allowance		Total incom	e		
vot tomo tour to	الم الم داد	TOTAL HICOHI	<u> </u>		
If income is \$0, please che Lives with relative(s)	CK all U	at appry:	Retired 1	Inemployed I	Disabled
Lives with relative(s)	T1462 M	ini iiieiin(2)	Trom on		
Homeless Other:					

Credit Card(s)   Car Payment(s)   Finance Companies   Other	Savings Account*		
Scourities of Deposit Scourities Other Please include a copy of most recent bank statement LIST YOUR OBLIGATIONS  Rent Credit Card(s)  Car Payment(s)  Finance Companies Other  Total Owed  Part B- Other Medical Obligations List all medical-related expenses outstanding (exclude ESH)  Name of Bill Balance Owed Monthly Payment  Have you applied for Medicaid (If yes, Please include a copy of approval or denial letter. If no, please explain why you have not done so.)  Part F- Documents  Part F- Documents  Proof of residency- for example a copy of a utility bill, credit card bill, etc. Personal correspondence (i.e. letter from a friend) is not acceptable.  Copy of 4 recent pay stubs for each person in the household with any type of income. W-2's are not acceptable as proof of income. If self-employed, please submit a complete copy of your current income tax return.  Copy of proof of any other income the household receives—social security, pension, food stamps child support, etc. Also please include a copy of your most recent bank statement;  You will be required to apply for assistance with Medicaid if we believe you qualify for benefits: The letter approving or denying your application will be needed with your application for assistance.  Please return the application and requested information to us within ten (10) days, so that a determination of eligibility can be made.  If you have any questions concerning this program or your account, please call (816) 629-2798.  Certify that the information is true and correct to the best of my knowledge and I give my permission to verify the above information and have attached proof of residency and income.  For Office Use Only	Savings Account.	Automobiles Ov	vned
Please include a copy of most recent bank statement  LIST YOUR OBLIGATIONS  Rent  Credit Card(s)  Critities  Car Payment(s)  Finance Companies  Other  Total Owed  Part E- Other Medical Obligations  ist all medical-related expenses outstanding (exclude ESH)  Name of Bill  Balance Owed  Monthly Payment  Fave you applied for Medicaid  (If yes, Please include a copy of approval or denial letter, If  to, please explain why you have not done so.)  Part F- Documents  Peace attach copies of the following documents:  Proof of residency- for example a copy of a utility bill, credit card bill, etc. Personal correspondence (i.e. letter from a friend) is not acceptable.  Copy of 4 recent pay stubs for each person in the household with any type of income. W-2's are not acceptable as proof of income. If self-employed, please submit a complete copy of your current income tax return.  Copy of proof of any other income the household receives - social security, pension, food stamps child support, etc. Also please include a copy of your most recent bank statement;  You will be required to apply for assistance with Medicaid if we believe you qualify for benefits: The letter approving or denying your application will be needed with your application for assistance.  Please return the application and requested information to us within ten (10) days, so that a determination of eligibility can be made.  f you have any questions concerning this program or your account, please call (816) 629-2798.  certify that the information is true and correct to the best of my knowledge and I give my permission to verify the above information and have attached proof of residency and income.  For Office Use Only	Cortificator of Denosit		S
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