EXCELSIOR SPRINGS HOSPITAL

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:

1. 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 _____ First Name_____Birthdate_____SSN_____

Address_____City_____State_____Zip_____
Home Phone_____Cell Phone_____Work Phone_____
Marital Status: Single___ Live-In Partner___ Married___ Separated___ Divorced___ Widowed___
Do any of your dependents have any accounts that need to be considered with this application?
Yes___ No___
Please list all account numbers, including any applicable dependent accounts:

Account Name	Account Number

Part B- Responsible Party Information

Examples include: spouse, live-in partner, parent, guardian, guarantor, etc.
If same as patient, skip Part B
Last Name _____ First Name_____Relationship to Patient_____
Address_____City_____State_____Zip_____

Part C- Dependents

List all dependents who reside in the applicant's home for whom the applicant takes financial responsibility. Check the appropriate relationship box for each dependent. **Attach an additional sheet if necessary.**

Name	Age	Spouse/partner	Parent	Child (under 21)	Other

Number of people in household_____ Number of children under age 21 in the home_____

Part D- Household Income & Assets

LIST BELOW THE INCOME OF ALL HOUSEHOLD MEMBERS
Wages_____ Year_____ Hour_____ (Please attach 4 current check stubs)
Farm/Self Employed_____ (Please attach complete current tax return)
Public Assistance_____ Child Support_____
Food Stamps_____ Military Allotment_____
Social Security_____ Pensions_____
Unemployment_____ Dividend, interest, rent_____
Workman's Compensation_____ Strike Benefits_____
Housing Allowance_____ Other_____
Total income_____

If income is $0, please check all that apply:
Lives with relative(s)____ Lives with friend(s)_____ Retired_____ Unemployed_____ Disabled_____
Homeless_____ Other:_____

LIST YOUR TOTAL ASSETS

Checking*_____ Real Estate Owned_____
Savings Account*_____ Automobiles Owned_____
Certificates of Deposit_____ Stock and Bonds_____
Securities_____ Other_____
*Please include a copy of most recent bank statement

LIST YOUR OBLIGATIONS

Rent_____ Credit Card(s)_____
Utilities_____ Car Payment(s)_____
Childcare_____ Finance Companies_____
Child Support_____ Other_____
Total Owed_____

Part E- 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

Please 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.

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

I 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.

Signature_____ Date_____

For Office Use Only

Account Number(s)_____ Approved_____ Date_____

Denied_____ Date_____