



**EXCELSIOR SPRINGS HOSPITAL  
1700 RAINBOW BLVD.  
EXCELSIOR SPRINGS, MO. 64024  
(816) 629-6511**

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, and assets.

Enclosed you will find an application for assistance; if you wish to apply, please return the completed form to the hospital Business Office for the Financial Counselor, 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.
4. Also please include a **copy of your most recent bank statement.**
5. **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) 629-6511.

Sincerely,  
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 ESH patient 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.)

\*\* Have you applied for Financial Assistance with another institution \_\_\_\_\_ (If yes, Please include  
 copy of the approval letter.)

## 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.

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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 \_\_\_\_\_

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For Office Use Only

Account Number(s) \_\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_

Denied \_\_\_\_\_ Date \_\_\_\_\_