SMITH COUNTY MEMORIAL HOSPITAL

Financial Assistance Application

Patient Information

_____

Last Name First Name Middle Initial Social Security Number Date of Birth

_____

Street Address City State Zip Code

_____

Mailing Address City State Zip Code

Account Numbers: _____Date(s) of Service:_____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Home Phone Number: _____ Work Phone Number: _____

Person Responsible for Paying the Bill

_____

Last Name First Name Middle Initial Relationship to Patient Social Security Number

_____

Employer's Name and Address (If Unemployed, how long) Business Phone

_____

Job Title Monthly Income-Gross Monthly Income-Net Length of Employment

Household Information

List **ALL** people living in the household, including applicant, spouse and all legal dependents able to be claimed on your tax return.

NAME	AGE	RELATIONSHIP TO PATIENT
		Self

Medicaid Application

Have you applied for Medicaid/State Assistance? ☐ Yes ☐ No

If yes, Case number: _____ Date Applied: _____

You can apply online at www.applyforKanCare.ks.gov

SMITH COUNTY MEMORIAL HOSPITAL

Monthly Household Income* Information

	PATIENT	SPOUSE/OR PERSON RESPONSIBLE
Gross Income		
Social Security		
Unemployment		
Pension		
Alimony/Child Support		
VA Benefits		
Real Estate Rental Income		
Stocks, Bonds, 401K		
Dividends and Interest from Investments		
Other-Student Loans, Public Assistance (food stamps)		
TOTAL INCOME		
TOTAL HOUSEHOLD INCOME:		

*If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

Monthly Household Expense Information

	TOTAL		TOTAL
Mortgage Rent		Groceries	
Electricity		Car Payment(s)	
Gas		Day Care	
Water/Sewer		Child Support/Alimony	
Phone/Cell Phone		Student Loans	
Cable/Internet		Medical Expenses	
TOTAL HOUSEHOLD INCOME:			

REQUIRED Documents to be turned in with your completed application:

- Current Bank Statement – 1
- Proof of Income for most recent complete month: i.e. pay stubs, social security, disability, pension
- Most recent Federal Income Tax Return (not just W-2)
- Medicaid Denial Letter
- Copies of all Unpaid Medical Bills

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the information submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeopardize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that may be available to help pay this hospital bill prior to completing this application.

If approved for Smith County Memorial Hospital's Financial Assistance Program, approval only to bills presented and attached to this application. Any new information including changes to income, changes to insurance or new hospital bills should be turned into the Smith County Memorial Hospital finance office and may be subject to new application and/or changes to approval status. The Financial Assistance Program applies only to charges exceeding $500.00.

Signature: _____ Date: _____