SEDGWICK COUNTY MEMORIAL HOSPITAL/VALLEY MEDICAL CLINIC

Confidential Financial Assistance Application

Patient's Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth and Guardian, if applicable\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for Medicare and/or Medicaid\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Results of the Application\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CHECK** any circumstances listed that causes you to seek financial assistance from Sedgwick County Memorial Hospital/Valley Medical Clinic

\_\_\_\_\_\_ I am not eligible for Medicare, Medicaid, Veteran’s benefits or any other state or federal government program

­­\_\_\_\_\_\_ I cannot afford private Health Insurance

\_\_\_\_\_\_ My employer does not offer health insurance benefits

\_\_\_\_\_\_ My employer offers health insurance, but the employee share is too high

­­­­\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST ALL** members of the family, starting with the Patient:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name | Relationship to Patient | Age | Work Place | Full or Part Time Employment |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

**LIST ALL** GROSS MONTHLY INCOME for all family members:

(Provide 1 month proof to all that apply to the family. Also provide a copy of driver’s license and social security card.)

|  |  |  |  |
| --- | --- | --- | --- |
| Employment (Include Tips) | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Unemployment Compensation | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| AFDC | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Child Support | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Pension | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Social Security | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Other | | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Total Gross Income | $\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

PROVIDE a copy of the below statements from the last 3 months on all accounts owned by any family member

Checking Account

Savings Account

Investments, including stocks and bonds

Trust Funds

Money Market Accounts

Mutual Funds

Other Investment Funds for which an early withdrawal will not cause a penalty

PLEASE ATTACH YOUR LAST 5 PAYCHECK STUBS, OTHER PROOF OF INCOME OR YOUR LAST FILED FEDERAL INCOME TAX RETURN.

I am applying for Financial Assistance for health care services. I hereby certify that the above information is true and correct to the best of my knowledge. I also understand that the appropriate documentation must be mailed or provided with this application.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do Not Write Below This Line**

**=============================================================================================**

Total number in household \_\_\_\_\_\_\_\_\_\_\_ Total Household annual income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fee Category Discount: \_\_\_\_\_\_\_\_\_\_

Rating Technician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_