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FINANCIAL ASSISTANCE APPLICATION FORM

Please list the account number and facility name for each account for which Financial Assistance is requested:

Account Number	Facility Name	Account Number	Facility Name
Account Number	Facility Name	Account Number	Facility Name
Account Number	Facility Name	Account Number	Facility Name

Patient/Guarantor			Social Security Number
Address			Telephone Number
City	St	Zip Code	Date of Birth

Spouse name			Social Security Number
Address			Telephone Number
City	St	Zip Code	Date of Birth

Names and ages of persons living in the household:

Name	Age	Relationship	Do you claim this person for tax purposes?

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Income: Pay Stubs for each job are required

Patient/Guarantor Employer			
Address		Telephone Number	
City	St / Zip Code	Job Title	
Gross Income	Hr/Wk/Mo	Net Income	Hr/Wk/Mo

Spouse Employer			
Address		Telephone Number	
City	St / Zip Code	Job Title	
Gross Income	Hr/Wk/Mo	Net Income	Hr/Wk/Mo

Other Income: This includes Self-Employment, Unemployment, Work Comp, Child Support, Alimony Social Security, Disability, Pensions and Retirements and all other cash income.

Source	Gross	Net	Hr/Wk/Mo

Financial:

Account Type	Name of Bank/Company	Balance
Checking Account		
Savings Account		
Investment Account		
Other Accounts		

Expenses:

Source	Monthly Payment	Owed To	Balance
Mortgage/Rent			
Auto Loan			
Auto Loan			
Furniture/Appliances			
Credit Card			
Credit Card			
Gas (for home)			
Water			
Power			
Telephone			
Cell Phone			
Cable			
Gas (auto)/bus fare			
Child Care			
Insurance			
Insurance			
Groceries			
Prescriptions			
Doctor/Clinic			
Doctor/Clinic			

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Please explain your current situation and your need for Financial Assistance: (If additional space is needed, please continue on a separate page.)

Statement of Truth

The information in this application for financial assistance, concerning my financial situation, is both complete and correct to the best of my knowledge. I understand that information given within this document is for the purpose of determining eligibility for financial assistance and that false or incomplete information will result in my disqualification for financial assistance.

I agree to grant the hospital access to any records necessary to verify the information given in this application. I understand that eligibility for financial assistance will not be approved until verification of my financial situation, and that any changes or corrections found will be applied to the application before determination of eligibility is made.

I also understand that if my request for financial assistance is not approved based on the criteria given within this form that I may ask for special approval from the hospital and the Board of Directors and also through the President. I understand that their decision will be made only on the basis of extraordinary circumstances applying to my case, and that their decision will be final.

I also verify that all other sources of funds which may be available to me for payment of this medical expense have been exhausted, including all State or Federal medical funds. However, should funds be available from any public or private source to cover any medical expense which might be associated with the care which is the basis of this application, I agree to apply for such funds. I also hereby authorize Pratt Regional Medical Center to pursue such funds, and/or make application on my behalf, by sharing any information I may have submitted herein. I hereby authorize Pratt Regional Medical Center, South Central Kansas Bone & Joint Center, Pratt Internal Medicine Group, St. John Clinic, Farmer Clinic, Sylvia Rural Health Clinic, and Surgicenter to make/share whatever credit inquiries/information they deem necessary in connection with this application or in the course of review or collection of any credit extended in reliance on this application. I authorize and instruct any person or consumer reporting agency to compile and furnish the hospital(s) any information it may have or obtain in response to such credit inquiries and agree that same shall remain your property whether or not credit is extended. I acknowledge receipt of the notice printed below provided by the hospital(s) to me at the time this application is made. Further, I hereby affirm that all statements made in this application are true and are given for the purpose of obtaining financial assistance.

Patient/Guarantor Signature _____ Date _____

Signature of Spouse (if married) _____ Date _____

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You must include all of the following for the application to be complete. You have 240 days from the first patient statement to apply for Financial Assistance. Please return everything to us within 14 days. If you have questions, please call 620-450-1188. You can return by mail to PRMC, Attn: Financial Counselor, 200 Commodore St, Pratt, KS 67124 or in person at the same address. **To be considered for financial assistance your medical condition at the time must be urgent or emergent.**

1. Copies of the last 4 pay stubs from each job for all those in the household who are employed
2. Copies of the two most current bank statements, including all accounts such as checking, savings, CD, money market
3. Social Security award letter
4. Letter of determination if you have applied for Medicaid, if not we can help you through the process
5. Most recent copy of tax return or a letter from the IRS stating you do not file taxes, we can help with the letter if needed
6. Unemployment or Workers Compensation letter if applicable.
7. Support form. If another party is paying expenses on your behalf, please complete the attached statement.

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Patient Information Request Form

Patients Name: _____

Due to the above patient listing no income to pay for basic living expenses we are requesting this statement be filled out in full.

Please fill out the requested information and check the support item for living expense that you provide for the above listed patient. Signing this form does not make you financially responsible for the bill, it only allows us to continue the Financial Assistance Application process for the patient.

Name of person providing support: _____

Relationship to the patient: _____

List the months provided: _____

( ) Rent or housing
( ) Utilities such as gas, electric and water
( ) Groceries
( ) Transportation
( ) Miscellaneous Please list _____