ADDENDUM D

Kingman Healthcare Center
Application for Financial Assistance

(Check all applicable providers)

____KHC ____ Family Clinic ____ Cunningham Clinic

PATIENT INFORMATION: Name _____ Age/DOB _____

Address _____ City, State, Zip _____

Social Security # _____ Phone # _____

Martial Status: Married Single Divorced Widowed Legally Separated Life Partner

Number of dependents in home _____ Age of dependents _____

Employer Name _____ Address/Phone _____

Title/Position _____ Length of Employment _____

Secondary Employer _____ Address/Phone _____

RESPONSIBLE PARTY INFORMATION: ____ Check if same as patient

Name _____ Age/DOB _____

Address _____ City, State, Zip _____

Social Security # _____ Phone # _____

Martial Status: Married Single Divorced Widowed Legally Separated Life Partner

Number of dependents in home _____ Age of dependents _____

Employer Name _____ Address/Phone _____

Title/Position _____ Length of Employment _____

Secondary Employer _____ Address/Phone _____

SPOUSE INFORMATION:

Name _____ Age/DOB _____

Address _____ City, State, Zip _____

Social Security # _____ Phone # _____

Employer Name _____ Address/Phone _____

Title/Position _____ Length of employment _____

Secondary Employer _____ Address/Phone _____

FINANCIAL STATEMENT

GROSS MONTHLY INCOME: (documentation required)

Source	Self	Spouse	Dependent	Total
Employment Wages	$ _____	$_____	$_____	$_____
Self-Employment	$_____	$_____	$_____	$_____
Unemployment	$_____	$_____	$_____	$_____
Work Comp	$_____	$_____	$_____	$_____
Child Support	$_____	$_____	$_____	$_____
Alimony	$_____	$_____	$_____	$_____
ADC/Food Stamps	$_____	$_____	$_____	$_____
Social Security	$_____	$_____	$_____	$_____
Disability	$_____	$_____	$_____	$_____
Pensions/Retirement	$_____	$_____	$_____	$_____
Other Income	$_____	$_____	$_____	$_____

TOTAL $_____

ASSETS:
Residence: Own_____ Rent _____ (If Owned) Estimated Value $_____ Unpaid $_____
Real Estate: Business/Farm/Rental Property Estimated Value $_____ Unpaid $_____

VEHICLES:
#1 Make/Model/Year _____ Estimated Value $_____ Unpaid $_____
#2 Make/Model/Year _____ Estimated Value $_____ Unpaid $_____

FINANCIAL/BANKING:
Name _____ Account Type _____ Balance $_____

Name _____ Account Type _____ Balance $_____

OTHER ASSETS: (i.e., boats, motor homes, motorcycles, antiques) Value $_____

MONTHLY EXPENSES

Mortgage/Rent $_____	Vehicle Payment $_____	Prescriptions $_____
Groceries $_____	Vehicle Fuel $_____	Child Care $_____
Gas (heating) $_____	Vehicle Insurance $_____	Medical bills $_____
Electricity $_____	Life Insurance $_____	Child Support $_____
Water/Sewer/Garbage $_____	Medical Insurance $_____	Other $_____
Phone/cable/Internet $_____	Home/Renters Insurance $_____	Other $_____

LIABILITIES

Creditor Name	Original Balance	Current Balance	Monthly Payment

The following documentation must be provided for the application to be considered:

1. Copies of last 3 months paystubs for all employers. If self-employed, statement of 3 months income/expenses.
2. Unemployment and/or Work Comp benefits letter.
3. Proof of child support/Alimony income.
4. Most current complete bank statement (includes checking, savings, CD, money market).
5. Most recently completed tax return.
6. Social Security benefit letter verifying the benefit amount.
7. Letter of determination from Health and Human Services. You may apply online at www.kancare.ks.gov. Click on the "Check Eligibility" button and complete the questions. Print out the results page.
8. Support form. If another party is paying your expenses on your behalf, complete the attached statement.

If the application is incomplete, it will be returned. We will not be responsible for follow up on incomplete applications.

COMPLETED APPLICATIONS MUST BE RETURNED WITHIN 14 DAYS OF RECEIPT.

To consider an account for financial assistance, your medical condition at the time of service **MUST** be urgent or emergent.

COMMENTS:

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

CERTIFICATION:

I certify the information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services at Kingman Healthcare Center. I understand that all information provided is subject to verification. I hereby grant permission to Kingman Healthcare Center personnel to receive, release, or act upon financial information contained herein. I also release Kingman Healthcare Center and any party from liability from any acts, communications, or disclosures which are made pursuant to such an investigation. I understand that if the information which I submit is determined to be false, such a determination will result in a denial of the application and I will be liable for all charges.

Promissory Note: When after the Application for Financial Assistance is processed and it is determined that I am responsible for all or portion of the remaining balance identified in attachment to this application and upon receipt of the determination letter, I will accept responsibility for the amount identified, if applicable.

_____ _____

Signature (Patient/Guarantor) Date

_____ _____

Signature of Spouse Date

FOR OFFICE USE ONLY:

Process date: _____ Approval/Denial (circle) Expiration Date:_____

Approval % rate _____

KINGMAN HEALTHCARE CENTER
750 W. D AVE
KINGMAN, KS 67068

_____ KHC _____ Family Clinic _____ Cunningham Clinic

Patient Information Request Form

Patient Name: _____

Since patient listed above has no source of income, our office requires an explanation on how basic living expenses are paid for.

Please fill out the information requested and check the support item for living expenses that you provide for the patient listed above. Signing this form does not make you financially responsible for the bill.

Name of person providing support: _____

Relationship to patient: _____ List months provided: _____

[ ] Rent or housing.
[ ] Utilities for living expenses (electricity, water, gas, etc.)
[ ] Groceries/food/etc.
[ ] Personal care items such as: soap for laundry/showers, etc.
[ ] Transportation provided (such as vehicle rides/gas/etc.)
[ ] Other misc expenses (list) _____

I certify that I provide the support indicated above for this patient.

_____ _____
Signature of person providing financial support Date