# *MEDICINE LODGE MEMORIAL HOSPITAL & PHYSICIANS CLINIC*

## FINANCIAL ASSISTANCE APPLICATION

(All fields must be completed unless noted otherwise)

| **Applicant Last Name, First** (and spouse if filing jointly) | **Date of Birth** | **Social Security Number** (for all applicants) | **Number of People in Household** | **How many of the total household occupancy are over 18 with an income?** |
|---|---|---|---|---|
| | | | | |

| **Applicant Street Address** | **City, State, Zip Code** | **Applicant's Hospital/Clinic Account Numbers & Balances:** |
|---|---|---|
| | | |

| **Applicant and Co-Applicant's Employer** | **Employer Address and Phone Number** | **Applicant Phone Number** |
|---|---|---|
| | | |

**Has the Patient applied for Medical Assistance? Denial Letter?**

| **Current Checking Account Balance:** | **Current Savings Account Balance:** | **Current Cash on Hand for everyone over 18:** |
|---|---|---|
| | | |

**Monthly income from any of the following for everyone over 18:**

| **Paycheck:** | **Disability:** | **State Assistance:** | **Food Stamps:** | **Child Support:** | **OTHER:** |
|---|---|---|---|---|---|
| | | | | | |

**Please read before signing.** I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE which may be available through federal, state, local goverment and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this hospital bill. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will reevaluate my financial status and take whatever action becomes appropriate. To qualify for assistance, most recent year's tax return for anyone's income included on this form along with several pay stubs from any other sources must accompany the application. Additional supporting documentation may be requested. Supporting documentation can include but is not limited to, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documenation is not provided. Any unpaid balance will be eligible for further collection action.

For assistance with this application, please call the Business Office at (620)930-3773.

Signature of Applicant:_____ Date Completed: _____

Signature of Co-Applicant:_____ Date Completed:_____