



APPLICATION FOR UNCOMPENSATED CARE & MEDICAL INDIGENT PROGRAM

Return Completed application with proof of income, etc to: JaNae Brown c/o Newman Regional Health 1201 W. 12th Ave Emporia, KS 66801

Patient's Full Name Service Requested Patient's Date of Birth Patient's SS# Guarantor's Full Name Spouse Phone Present Street Address City State Zip Previous Address if above is less than two years Employer Spouse Employer Name of nearest relative not living with you Address Relationship Phone

LIST BELOW, THE TOTAL FAMILY ANNUAL INCOME OF ALL THE MEMBERS OVER 18 YEARS OF AGE:

Wages Alimony Farm or Self Employ Child Support Public Assistance Military Family Allotment Social Security Pensions Unemployment Comp Dividends, Interest, Rent Workman's Comp Strike Benefits TOTAL INCOME

LIST BELOW, THE TOTAL FAMILY ASSETS: \$

Checking Account Real Estate Owned Savings Account Automobile Owned Certificate of Deposit Stocks & Bonds Securities Other: * Farm Equip/Livestock

LIST BELOW, YOUR TOTAL OBLIGATIONS:\$

Rent Credit Card Payment House Payment Finance Companies Car Payment Make & Model of Cars Other TOTAL OBLIGATIONS

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I GIVE PERMISSION TO VERIFY THE ABOVE INFORMATION.

Signature Date Number of Household Members Ages of Household Members Approved Date Denied Date Comments:

**NEWMAN REGIONAL HEALTH
UNCOMPENSATED & MEDICAL INDIGENT HEALTH CARE
PROGRAM**

STATEMENT OF PURPOSE

To provide assistance for healthcare to patients who cannot afford to pay and who are not covered by other programs including health insurance, or who are not eligible for benefits from the Jones Foundation or other charitable funds. Written notice of non-qualification may be requested. This facility does not discriminate against a patient because of race, creed, color or national origin. Patient eligibility is determined by family income and assets.

GUIDELINES – VERIFICATION OF INCOME AND ASSETS

Patient eligibility for uncompensated health care is determined by measuring family income against the Income Poverty Guidelines established by the Community Services Administration. To verify annual income, the applicant will be required to provide the following:

1. Must be a U.S. Citizen (an exception must be approved by the CFO).
2. Current Pay Stubs
3. Copy of your most current income tax return, including all schedules.
4. Any applicable forms approving or denying unemployment compensation or Workers' Compensation.
5. Written verification of wages from employer if pay stubs are not available.
6. Written verification of public welfare agencies.

2019 POVERTY GUIDELINES

<u>Size of Family</u>	<u>Annual Family Income</u>
1	\$12,490
2	16,910
3	21,330
4	25,750
5	30,170
6	34,590
7	39,010
8	43,430

- * For family units with more than 8 members, add \$4,320 for each additional member
- * Students, regardless of their residence, who are supported by their parents or other related by birth, marriage, or adoption are considered to be residing with those who support them.
- * Assets are reported as a part of the application. If there is sufficient assets to pay account, then payment will be expected.
- * Applications must be completed within 90 days of service. Determination of eligibility will be made within thirty working days and the applicant will receive written notice of acceptance or denial.
- * Applications may be obtained from the Credit/Collections Coordinator or the patient Accounts Supervisor in the Patient Accounts Department Monday through Friday from 8:00 a.m to 4:30 p.m.

MEDICAL INDIGENT GUIDELINES

For medical bills that are more than 50% of applicants household gross income. Applicant must provide proof of all outstanding medical expenses.