NEWMAN
REGIONAL HEALTH

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 assests.

GUIDELINES − VERIFICATION OF INCOME AND ASSESTS

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.

2020 POVERTY GUIDELINES

Size of Family	Annual Family Income
1	$12,760
2	17,240
3	21,720
4	26,200
5	30,680
6	35,160
7	39,640
8	44,120

- For family units with more than 8 members, add $4,480 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.

Form #1894 Reviewed: 02/12/20 Revised: 02/12/20