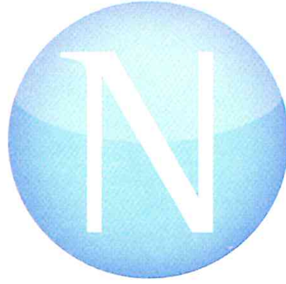

NEWMAN

REGIONAL HEALTH

Thank you for requesting the application for the Financial Assistance Program. We are asking that you please provide income verification along with the application. You may return all your information in the self addressed stamped envelope enclosed. This will help us expedite the handling of your application in a timelier manner. If the information is not received, it will delay the application process and could possibly make you ineligible for the program. We require proof of income for all household members. Below you will find the list of information that will be requested from you if applicable:

1. Current Pay Stubs from your employer
2. Copy of your most recent income tax return, including **ALL** schedules
3. Any applicable forms approving or denying unemployment compensation or Worker's Compensation.
4. Written verification of wages from employer if pay stubs are not available
5. Written verification of public welfare agencies.
6. If self-employed, we will need an income/expense statement showing year to date.
7. If retired or disabled and drawing social security benefits, we will need a bank statement showing the deposit amount or a letter from Social Security with the benefit amount listed.

Our goal is to assist you with your financial needs regarding your medical expenses. If you have any questions regarding this application or the proof of income guidelines, please contact us.

Sincerely,

JaNae Brown
Credit/Collection Coordinator
620-343-6800, ext 25114

APPLICATION FOR
FINANCIAL ASSISTANCE PROGRAM

Return Completed application
with proof of income, etc to:

Newman Regional Health
Attn: Credit & Collections Coord
1201 W. 12th Ave
Emporia, KS 66801

Patient's Full Name ______ Service Requested ______

Patient's Date of Birth ______ *Patient's SSN ______

Guarantor's Full Name ______ Spouse ______ Phone ______

Present Street Address ______ City ______ State ______ Zip ______

Previous Address if above is less than two years ______

Employer ______ Spouse Employer ______

Number of Household Members ______ Ages of Household Members ______

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	______	Pensions	______
Social Security	______	Dividends, Interest, Rent	______
Unemployment Comp	______	Other	______
TOTAL INCOME	______		______

***LIST BELOW, THE TOTAL FAMILY ASSETS:** $ ______

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

LIST BELOW, YOUR TOTAL OBLIGATIONS: $ ______

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

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 ______

Approved: ______ Date ______ Denied: ______ Date ______

Comments: ______

* Items not required for emergency room and primary care visits

NEWMAN REGIONAL HEALTH
FINANCIAL ASSISTANCE PROGRAM

STATEMENT OF PURPOSE

To provide financial assistance for healthcare to patients who cannot afford to pay and who are not covered by health insurance, or who are not eligible for benefits from the Jones Foundation or other charitable funds.

GUIDELINES − VERIFICATION OF INCOME AND ASSESTS

Patient eligibility for financial assistance 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. Current Pay Stubs
2. Copy of your most current income tax return, including all schedules.
3. Any applicable forms approving or denying unemployment compensation or Workers' Compensation.
4. Written verification of wages from employer if pay stubs are not available.
5. 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.
- 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 Supervisor in the Patient Accounts Department Monday through Friday from 8:00 a.m to 4:30 p.m.

MEDICAL INDIGENCY GUIDELINES

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