



**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	_____
<b>TOTAL INCOME</b>	_____		_____

**\*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  
UNCOMPENSATED & MEDICAL INDIGENT HEALTH CARE  
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 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. 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.

**2021 POVERTY GUIDELINES**

<u>Size of Family</u>	<u>Annual Family Income</u>
1	\$12,880
2	17,420
3	21,960
4	26,500
5	31,040
6	35,580
7	40,120
8	44,660

- For family units with more than 8 members, add \$4,540 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 INDIGENT GUIDELINES**

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