



NEWMAN

REGIONAL HEALTH

Thank you for requesting the application for the Financial Assistance Program. We are asking you to please provide income verification along with the application. You may return all your information using 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.
8. The last two monthly bank statements.

Our goal is to assist you with your financial needs regarding your medical expenses. Approved applications are valid for 6 months from decision date. If you have any questions regarding this application or the proof of income guidelines, please contact us.

Sincerely,

Kim Smith
Credit/Collection Coordinator
620-343-6800, EXT 25114

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.

2025 POVERTY GUIDELINES

<u>Size of Family</u>	<u>Annual Family Income</u>
1	\$15, 650
2	21, 150
3	26, 650
4	32, 150
5	37, 650
6	43, 150
7	48, 650
8	54, 150

- For family units with more than 8 members, add \$5, 500 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.



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