Newton Medical Center
600 Medical Center Drive | Newton, KS 67114

HEALTHCARE ASSISTANCE APPLICATION

See NMC's Healthcare Assistance Policy (HCA 501R) for eligibility criteria.

Date: _____

SECTION I: DEMOGRAPHICS

Patient Name _____ SSN _____ Account #_____
_____
_____
Guarantor's Name _____
Address _____ DOB_____
City, State Zip_____ Gender: ____M ____F
Marital Status: ___Single ___Married ___Divorced ___Widow ___Separated
Contact Numbers: Home Phone (___)_____ Work (___)_____
Cell (___)_____
Are you a US Citizen? _____ Legal Permanent Resident? _____
What county do you reside? _____

SECTION II: CURRENT INCOME, EXPENSES & BANKING INFORMATION

Monthly Income	Patient	Spouse/Co-Applicant
A. Gross Income (before deductions)		
B. Net Income (after deductions)		
C. Income from Business (if self-employed)		
D. Social Security/SSI		
E. Retirement		
F. Alimony or Child Support		
G. Interest and Dividends		
H. Real Estate Income		
I. Other Income		
Total Current Monthly Income (total B-I)		
Total Current Monthly Income patient/spouse		

Checking Acct Balance $_____ Savings Acct Balance $_____
Do you have other banks accounts? _____No_____ Yes (if yes, attach a separate sheet with banking information)

FAMILY STATUS: List household members by legal name. Proof of income may be required

	NAME	DOB	Age	SSN	RELATIONSHIP	GROSS INCOME
1.						$
2.						$
3.						$
4.						$
5.						$
6.						$
7.						$

Is anyone in the household pregnant? _____ Who? _____ Relationship _____

CDs / Stocks / Bonds	$_____	Retirement / 401k / IRA	$_____
Safe Deposit Box	$_____	Rental Property	$_____
RV / Trailer / Boat / ATV	$_____	Livestock / Land	$_____
Whole / Term Life Ins	$_____	Burial Policy	$_____
Secondary Residence	$_____	Real Estate	$_____
Promissory Note	$_____	Personal Injury Claims	$_____

EMPLOYMENT INFORMATION:

If not working at this time, when did you last work? _____

INFORMATION OBTAINED FROM: _____ RELATIONSHIP TO PATIENT: _____

I would like to apply for financial assistance through Newton Medical Center. I understand that it is the expectation of Newton Medical Center that the patients use all of the available financial resources to pay their medical bills before financial assistance will be granted.

The information I have provided above is true and complete. By signing this form, I agree to allow Newton Medical Center to check employment and credit history for the purpose of determining my eligibility for financial assistance. I also agree to allow organization and facilities to release information concerning my financial status to Newton Medical Center for the purpose of determining my eligibility for financial assistance. I understand that I may be required to provide proof of the information I am providing. If this information is found to be false or misleading, I understand my application will be denied.

_____ _____

Applicant's Signature Date Co-Applicant's Signature Date

PLEASE RETURN TO CATHERINE RYAN, MIDLAND GROUP: 1310 WAKARUSA DR, LAWRENCE, KS 66049 OR FAX TO 785-840-9677. FOR QUESTIONS PLEASE CALL 785-330-7278 OR 316-201-9254

Any application without signatures and the necessary documentation will no be processed until information is received. In order for Newton Medical Center to assist you in completing your application for public benefits and/or financial assistance or additional discounts the following information and documentation must be provided no later than _____.

- **HEALTHCARE ASSISTANCE APPLICATION (application must be signed by spouse if married)**
  - Complete entire application.
- **PROOF OF ALL GROSS INCOME (before taxes)**
  - Copies of paycheck or pension stubs or letter from employer for the 3 months prior to the date of service.
  - Copy of Social Security statements for each person
  - Court order for Child Support or Alimony
  - Unemployment benefits confirmation letter
  - Any other sources of income
  - Copy of checking/savings accounts statements for last 90 days
- **COPY OF PREVIOUS YEAR'S FEDERAL INCOME TAX RETURN IF YOU WERE REQUIRED TO FILE.**
  - Copies may be obtained by contacting the IRS at 1-800-829-1040
  - If you were not required to file, we need copies of your W-2

If no income and not supporting yourself, we require a written statement from whoever is supporting you.