Dear Patient,

Enclosed is our Financial Assistance Application for Minneola District Hospital. If you are interested in applying for assistance directly through our facility, please fill out the form and return it to the hospital as soon as possible.

Remember, you must include all persons living in the household's information. Please drop off this information or mail to:

Minneola District Hospital
PO Box 127
Minneola, KS 67865

Also, you need to include a copy of the following information for income verification purposes:

1. Last 2 months of Employer pay stubs.
2. Written documentation from income sources.
3. Copy of all bank statements for the last 2 months.
4. Year, make, model, and mileage on all vehicles.
5. Federal income tax return for the most current year.
6. Proof of credit card debt.
7. Proof of medical debt.
8. Proof of denial or approval for Medicaid; if denied, denial letter must be no more than 60 days old.

Please be sure to include **ALL** the requested information with your application. This will ensure complete and timely processing. If any information is excluded, your application will be denied. If you have any questions or need further assistance, please reach out to billing@minneolahealth.com or call our direct line at 620-885-3045. A letter of determination will be sent to you after a decision is made about your application.

Sincerely,

Minneola Healthcare Billing Team

Personal Financial Statement for Financial Assistance

Patient Name	Age	Phone Number	Marital Status S M W D	Social Security Number

Date Pt. Received:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $
Please Return By:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $
Date Returned:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $

Patient		**Person Responsible for Bill (if not patient)**	**Relationship**
Street:		Name:	
		Street	
City, ST, Zip		City, ST Zip	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, Name of Last Employer:	If unemployed, Name of Last Employer:
How Long Unemployed?	How Long Unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes _____ No _____

If yes, why not available for this date of service? _____

If no, please indicate the reason for lack of insurance coverage? Insurance cost too high? Yes_____ No_____;
Pre-existing condition? Yes_____ No_____; Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date: _____ Reason for Denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income			
	Patient	**Spouse**	**Other Members of Household (18 and older)**
Wages (Gross)	$	$	
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List			
MONTHLY INCOME SUBTOTAL			
TOTAL INCOME:	**MONTHLY: $**		**YEARLY: $**

EXPENSES	**Remaining Balance**	**Monthly Payment**
Mortgage or Rent Payment	$	$
Car Payment		
Utilities (Gas, Electric, Water		
Cable		
Phone (Including Cell)		
Food		
Child Care		
Clothing		
Insurance (Auto, Life, Health)		
Gas/Transportation		
Recreation		
Physicians		
Hospitals		
Other Medical		
Credit Cards		
Other Expenses (Describe)		
TOTAL EXPENSES:	$	$

HOUSEHOLD ASSETS	**VALUE**
Savings	$
Checking	
Stocks and Bonds	
Mutual Funds, Money Marekt, etc.	
Cash Value of Life Insurance	
Real Estate Value	
Farming Real Estate Value	
Vehicles Value (not primary)	
Jewelry & Other Personal Property	
Other Assets (Describe)	
TOTAL HOUSEHOLD ASSETS:	$

HOUSEHOLD DEBTS	**VALUE**
Home Loan	$
Auto Loan	
Credit Card Debt	
Other: Total Expenses from "Balance Due"	
column - (Mortgage + Car Loan + Cr, Cards)	
TOTAL HOUSEHOLD DEBTS:	$

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date:

Application Determination: Approved / Denied Date Determination Letter Mailed: _____

Approval Amount: _____ _____

Reason for Denial: _____

Hospital Representative Signature(s) Date: