



CITIZENS
HEALTH

Date Received / Initials

FINANCIAL ASSISTANCE APPLICATION

In our mission to serve the healthcare needs of residents of Northwest Kansas, Citizens Health is committed to making care affordable. We offer discounts, payment options, and financial assistance to people who cannot afford to pay for medical care, including Emergency Department services. Citizens Medical Center, NWKS Surgical Associates, and Family Center for Health Care offers medically necessary services in our facility at a discounted rate or free of charge if you are an eligible candidate under the Financial Assistance Program (FAP). The Financial Assistance policy and procedure is available on request by calling 785-460-5640 or available on the Citizens Health website: www.cmciks.com

Instructions: All questions must be answered. If a question does not pertain to you, please write N/A.
Return the completed application with supporting documents requested in the application to the Financial Counselor office at Citizens Medical Center: 100 E College Dr, or email them to billing@cmciks.com.

Patient (Over age of 18) or Parent/Guardian Information

Name: _____ DOB: ____ / ____ / ____

Street Address: _____ City: _____

State: _____ Zip: _____ Phone Number: () _____ Email Address: _____

Marital Status: _____ **Household Size (including applicant):** _____

US Citizen or Permanent Resident ☐ Y ☐ N SSN: _____ - _____ - _____

Employment Status:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Employer Name and Address: _____

If Unemployed, Please provide dates of unemployment period: From _____ To _____

If you rely on student loans to pay for basic living expenses, please provide copies of student loan and allocations.

How often are you paid: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly

Monthly Salary (Prior to taxes): _____

Are you claimed on someone else's taxes as a dependent: ☐ Y ☐ N

Please check all the boxes that apply to the patient or household

Is the applicant covered by health insurance? ☐ Y ☐ N

Has the applicant applied for Medicaid benefits within the last 3 months? ☐ Y ☐ N

Is the applicant pregnant, under the age of 19, a caretaker of a child, over the age of 65, or disabled? ☐ Y ☐ N

If the patient has been denied Medicaid within the last 3 months, please attach a copy of the denial notice.

Does the patient have a lawsuit, settlement, personal injury, work comp, or liability claim pending? ☐ Y ☐ N

Would you be interested in finding out if you'd qualify for insurance coverage? ☐ Y ☐ N

Do you feel like you are unable to receive the medical care, including mental health services, you need because of the financial burden it may cause? ☐ Y ☐ N

Do you have any medical expenses from other organizations that you are struggling to pay for? If so, please list the organization and amount. ☐ Y ☐ N

Household Member Information (including applicant): (If more than 6 members use separate page)
Approval Requires proof of most recent tax return

Full Name	DOB	Relationship to applicant	Claimed on Taxes?	Claimed on Insurance?	Guarantor (Office use only)
	___/___/___		☐ Y ☐ N	☐ Y ☐ N	
	___/___/___		☐ Y ☐ N	☐ Y ☐ N	
	___/___/___		☐ Y ☐ N	☐ Y ☐ N	
	___/___/___		☐ Y ☐ N	☐ Y ☐ N	
	___/___/___		☐ Y ☐ N	☐ Y ☐ N	
	___/___/___		☐ Y ☐ N	☐ Y ☐ N	

Gross Monthly Income for all household members: Approval requires proof of most recent 2 months income

Employment Wages:	\$ _____	Workers Comp:	\$ _____
Pension/Retirement:	\$ _____	Child Support	\$ _____
Rental Income:	\$ _____	SSI/SSDI Social Security:	\$ _____
Short/Long Term Disability:	\$ _____	Other (Including Side Jobs) i.e. Door Dash, Etsy business, Etc.	
Unemployment	\$ _____	\$ _____	

Asset Information: Approval requires proof of all assets for the last two months (most recent 2 bank statements)

Checking Balance: \$ _____ Savings Balance:\$ _____ CD: \$ _____

Stocks/Bonds: \$ _____ 401K: \$ _____ Other: \$ _____

To help better understand your needs, please describe your current financial situation and why you are unable to pay your balance or make monthly payments. Please be specific (Use separate sheet if needed)

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. CMCI retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to CMCI to obtain information from any source to verify the statements I (we) have made.

☒

Did you remember to:

☐

Attach 2 months income proof

☐

Attach 2 months bank statements

☐

Attach most recent tax return

Patient/Guarantor Signature: _____

Date: _____

Administrative Signature: _____

Date: _____

Explanation of Missing Documentation

Please provide an explanation for why you are unable to provide the required documentation for your financial assistance application.

I am unable to provide 2 months of bank statements because:

I am unable to provide 2 months of income proof because:

I am unable to provide my most recent tax return because:

I am unable to provide other documentation (e.g., disability statements, Social Security Income verification, Medicaid Denial Letter, etc.) because:

Attestation Statement

*By signing below, I affirm that I am unable to provide the requested documentation as indicated above and that all the information I have provided is true and accurate to the best of my knowledge.
I understand that by completing this attestation, I may still be required to provide additional documentation in the future to verify my financial status. I also understand that providing false information may result in denial of my financial assistance application or the reversal of any approved assistance.*

Patient/Guarantor Signature: _____ Date: _____

Administrative Signature: _____ Date: _____