Request for Financial Assistance

OSBORNE COUNTY MEMORIAL HOSPITAL
GOAD MEDICAL CLINIC
PO BOX 70
OSBORNE, KS 67473

Dear Patient and Family:

In keeping with its mission and core values, Osborne County Memorial Hospital is committed to providing health care for people regardless of their ability to pay.

Financial Assistance: Medical bills may be difficult to pay. Patients who do not have health insurance and who are unable to pay for all or part of their health care services, may apply for financial assistance by completing and returning this form.

Options Available: Osborne County Memorial Hospital, Goad Medical Clinic and Osborne County Medical Clinic staff will work with patients, who are interested, to see if they qualify for Medicaid, Medicare, private insurance, interest free payment plan options, or financial assistance. If financial assistance is granted, some or all charges may be lowered.

Application Process To apply for financial assistance, complete and return this form to Osborne County Memorial Hospital/Goad Medical Clinic, P.O. Box 70, Osborne, KS 67473

The following information must be included with the application:

- Current Bank Statement -1
- Proof of Income for the most recent complete month: e.g., pay stubs, social security, disability, pension
- Most recent Federal Income Tax Return (not just W2)
- Medicaid denial letter
- Copies of all Unpaid medical bills

Questions? Please call our business office or social services office at
785-346-2121 Monday – Friday 8 a.m. to 5 p.m.

This completed application, including the supporting information, should be returned within 14 days of receipt.

By submitting application for assistance, patients give Osborne County Memorial Hospital/Goad Medical Clinic/Osborne County Medical Clinic consent to make necessary inquiries to confirm financial obligations or references.

Financial Assistance Application

Patient Information

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Street Address	City	State	Zip code

Mailing Address	City	State	Zip code

Account Numbers:	Date(s) of Service:

Marital Status: Single Married Separated Divorced Widowed (circle one)

Home phone number: _____ Work/Cell phone number: _____

PERSON RESPONSIBLE FOR PAYING THE BILL

Last Name	First Name	Middle Initial	Social Security Number	Date of Birth

Employer's Name and Address (if unemployed, how long?)

_____

Job Title Length of Employment

Monthly Income:

Gross Monthly: _____ Net Monthly:_____

Household Information

List ALL people living in the household, including applicant, spouse and all legal dependents able to be claimed on your tax return.

Name	Age	Relationship to patient

Medicaid Application

Have you applied for Medicaid/State Assistance? Yes No

If yes, Case number: _____ Date Applied: _____

You can apply online at www.applyforKanCare.ks.gov

OCMH
Our Specialty is You

Monthly Household Income* Information

	Patient	Spouse/ or person responsible
Gross Income		
Social Security		
Unemployment		
Pension		
Alimony/Child Support		
VA Benefits		
Real Estate Rental Income		
Stocks, Bonds, 401K		
Dividends and Interest from Investments		
Other-Student Loans, Public Assistance (food stamps)		
TOTAL INCOME		
TOTAL HOUSEHOLD INCOME		

*If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

Monthly Household Expense Information

	TOTAL		TOTAL
Mortgage Rent		Groceries	
Electricity		Car Payment(s)	
Gas		Day Care	
Water/Sewer		Child Support/Alimony	
Phone/Cell phone		Student Loans	
Cable/Internet		Medical Expenses	
TOTAL HOUSEHOLD EXPENSE			

REQUIRED Documents to be turned in with your completed application:

- ✓ Current Bank Statement - 1
- ✓ Proof of Income for the most recent complete month: eg pay stubs, social security, disability, pension
- ✓ Most recent Federal Income Tax Return (not just W2)
- ✓ Medicaid denial letter
- ✓ Copies of all Unpaid medical bills

I, the undersigned, certify that the above information is true and accurate to the best of my knowledge. I understand that the informaation submitted is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted may jeoparize my consideration for the program. Furthermore, to qualify for this program, I understand I must apply for any and all assistance that my be available to help pay this hospital bill prior to completing this application.
If approved for Osborne County Memorial Hospital's Financial Assistance Program, approval only to bills presented and attached to this application. Any new information including changes to income, changes to insurance or new hospital bills should be turned into Osborne County Memorial Hospital finance office and may be subject to new application and or/changes to approval status.

Signature: _____ Date: _____