HUTCHINSON
REGIONAL MEDICAL CENTER

FINANCIAL ASSISTANCE APPLICATION

Thank you for choosing Hutchinson Regional Medical Center for your healthcare needs. Enclosed you will find a financial assistance application.

Please complete the information requested and provide all documents necessary to adjudicate your application. Failure to provide all documents may result in the application being denied.

We require:

1. **Complete copy of current year's tax return**
2. **Three (3) most recent pay stubs from employment**
3. **Complete bank statement of the past 30 days of activity**

Please note: If you are not currently employed, please provide verification of income. (Social Security determination letter, Kansas Dept of Labor unemployment compensation, DCF letter proving qualification for the following: Food Stamps, Cash Assistance).

Please take the time to contact the physician billing services connected with Hutchinson Regional Medical Center to notify them that you are applying for Financial Assistance at 620-665-2515. These bills are your responsibility.

If you need assistance in completing the application or have questions, please call 620-665-2024.

HUTCHINSON
REGIONAL HEALTHCARE SYSTEM

This information obtained will be kept confidential and used only for Financial Assistance determination.

Financial Assistance Application Form "A"

Patient Name: _____ Patient Account #(s) _____

Responsible Party Name (if patient is a minor): _____ SS# _____

Spouse/Partner's Name:_____ SS# _____

Physical Address: _____

_____

Mailing Address: _____

_____

Number of family members living in the home (spouse/partner and dependents):_____

Have you recently made, or plan to make an application for Medicaid and/or Medical Assistance?

☐ YES _____

☐ NO Date of Application(s): _____

Income Verification (List all persons in household who are employed):

Name	Relationship to Patient	Employer's Name & Address	Monthly Income	
			Gross	Net
			$	$
			$	$
			$	$
			$	$
			$	$
			$	$

Other Income (List monthly amounts):

Name	Relationship to Patient	Child Support	Unempl. Comp.	TANF	Social Security	SSI	VA	Other Income
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$

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Financial Assistance Application Form "B"

Name: _____

Monthly Expenses	Monthly Payments	Current Balance
Food		
Rent / House Payment		
Gas - House		
Electricity		
Water, Trash, and Sewer		
Cable Television / Satelite		
Telephone		
Gas (Car) / Transportation		
Car Payment		
Car / House Insurance		
Health / Life Insurance		
Prescriptions		
Doctors / Healthcare Providers		
Credit Cards		
Other		

Total Monthly Income: _____

Total Monthly Expenses: _____

Signature: _____

Date: _____ **Phone Number:** _____

Email: _____