PRATT • REGIONAL MEDICAL • CENTER

FINANCIAL ASSISTANCE APPLICATION FORM

Please list the account number and facility name for each account for which Financial Assistance is requested:

Account Number	Facility Name	Account Number	Facility Name
Account Number	Facility Name	Account Number	Facility Name
Account Number	Facility Name	Account Number	Facility Name

Patient/Guarantor	Social Security Number
Address	Telephone Number
City St Zip Code	Date of Birth

Spouse name	Social Security Number
Address	Telephone Number
City St Zip Code	Date of Birth

Names and ages of persons living in the household:

Name	Age	Relationship	Do you claim this person for tax purposes?

PRATT • REGIONAL MEDICAL • CENTER

Income:

Patient/Guarantor Employer			
Address		Telephone Number	
City	St Zip Code	Job Title	
Gross Income	Hr/Wk/Mo	Net Income	Hr/Wk/Mo

Spouse Employer			
Address		Telephone Number	
City	St Zip Code	Job Title	
Gross Income	Hr/Wk/Mo	Net Income	Hr/Wk/Mo

Other Income:

Source	Gross	Net	Hr/Wk/Mo

Financial:

Account Type	Name of Bank/Company	Balance
Checking Account		
Savings Account		
Investment Account		
Other Accounts		

PRATT • REGIONAL MEDICAL • CENTER

Expenses:

Source	Monthly Payment	Owed To	Balance
Mortgage/Rent			
Auto Loan			
Auto Loan			
Furniture/Appliances			
Credit Card			
Credit Card			
Gas (for home)			
Water			
Power			
Telephone			
Cell Phone			
Cable			
Gas (auto)/bus fare			
Child Care			
Insurance			
Insurance			
Groceries			
Prescriptions			
Doctor/Clinic			
Doctor/Clinic			

Property:

		Purchase Date	Purchase Date
House Location			
Land Location			

	Year	Make/Model	Current Value
Automobile:			
Automobile:			
Automobile:			
Rec Vehicle:			

PRATT • REGIONAL MEDICAL • CENTER

Please explain your current situation and your need for Financial Assistance: (If additional space is needed, please continue on a separate page.)

Statement of Truth

The information in this application for financial assistance, concerning my financial situation, is both complete and correct to the best of my knowledge. I understand that information given within this document is for the purpose of determining eligibility for financial assistance and that false or incomplete information will result in my disqualification for financial assistance.

I agree to grant the hospital access to any records necessary to verify the information given in this application. I understand that eligibility for financial assistance will not be approved until verification of my financial situation, and that any changes or corrections found will be applied to the application before determination of eligibility is made.

I also understand that if my request for financial assistance is not approved based on the criteria given within this form that I may ask for special approval from the hospital and the Board of Directors and also through the President. I understand that their decision will be made only on the basis of extraordinary circumstances applying to my case, and that their decision will be final.

I also verify that all other sources of funds which may be available to me for payment of this medical expense have been exhausted, including all State or Federal medical funds. However, should funds be available from any public or private source to cover any medical expense which might be associated with the care which is the basis of this application, I agree to apply for such funds. I also hereby authorize Pratt Regional Medical Center to pursue such funds, and/or make application on my behalf, by sharing any information I may have submitted herein. I hereby authorize Pratt Regional Medical Center, PRMC Clinic Services, South Central Kansas Bone & Joint Center, Pratt Internal Medicine Group, Kinsley Rural Health Clinic, St. John Clinic, Farmer Clinic, Sylvia Rural Health Clinic and Surgicenter to make/share whatever credit inquiries/information they deem necessary in connection with this application or in the course of review or collection of any credit extended in reliance on this application. I authorize and instruct any person or consumer reporting agency to compile and furnish the hospital(s) any information it may have or obtain in response to such credit inquiries and agree that same shall remain your property whether or not credit is extended. I acknowledge receipt of the notice printed below provided by the hospital(s) to me at the time this application is made. Further, I hereby affirm that all statements made in this application are true and are given for the purpose of obtaining financial assistance.

Patient/Guarantor Signature _____ Date _____

Signature of Spouse (if married) _____ Date _____