THE UNIVERSITY OF KANSAS HEALTH SYSTEM

FINANCIAL ASSISTANCE APPLICATION			Please send completed application and all required supporting documents to: The University of Kansas Health System, PO BOX 955801, St Louis, MO 63195-5801
MRN#			
Guarantor #			
PATIENT INFORMATION			
Patient Name: (first, middle, last)			Is patient a US Citizen? ☐ Yes ☐ No Permanent Resident? ☐ Yes ☐ No
Patient Date of Birth:		Patient Social Security #	

INSURANCE INFORMATION

Is patient covered by health insurance?	☐ Yes	☐ No
Has patient applied for Medicaid benefits within the last 6 months?	☐ Yes	☐ No
If No, please explain why:		
Has patient been denied Medicaid benefits within the last 6 months?	☐ Yes	☐ No
If patient was denied Medicaid benefits within the last 6 months, please attach a copy of the denial notice		
Does patient have a lawsuit, settlement, personal injury, work comp, or liability claim pending?	☐ Yes	☐ No

Please check all boxes that apply to the patient, and attach the supporting documentation

☐	Patient Medicaid eligible but not on date of service, or not eligible for non covered services		
☐	Patient deceased	Date of Death:	
☐	Patient incarcerated	Date of incarceration:	
☐	Patient homeless	Explain:	

GUARANTOR INFORMATION

Guarantor Relationship to Patient:	☐ Self	☐ Spouse	☐ Mother	☐ Father	☐ Grandparent
☐ Other (explain)					
Guarantor Name: (first, middle, last)					
Street Address:					
City:		State:		Zip:	
Guarantor Home #:		Cell #:			
Guarantor Social Security #:		Guarantor Date of Birth:			
Household size:		Martial status:	☐ Single	☐ Married	☐
Employment status:		☐ Divorced	☐ Legally separated	☐	
☐ Full Time		*If legally separated, please attach legal separation notice*			
☐ Part Time		☐ Widowed			
☐ Self Employed					
☐ Unemployed	*(if unemployed please provide dates of unemployment in section below)*				
☐ Student	*If you are a student and rely on student loans to pay basic living expenses, please provide copies of student loan amounts and allocations*				
Employer Name and Address:					
Hire Date:		How often are you Paid?	Weekly ☐	Bi-weekly ☐	
Are you claimed on someone else's taxes as a dependent?	☐ Yes		Monthly ☐	Semi-monthly ☐	
	☐ No	If Unemployed, please provide dates of unemployment period:			
Gross Monthly Salary:		From:		To:	

SPOUSE INFORMATION									
Spouse Name: (first, middle, last)									
Spouse Social Security #						Date of Birth:			
Employment Status:	☐ Full Time	☐ Part Time	☐ Self Employed			☐ Student	☐ Unemployed		
If Unemployed, please provide dates of unemployment period:						From:		To:	
Employer Name and Address:									
Hire Date:			How often are you Paid?			Weekly	☐	Bi-weekly	☐
						Monthly	☐	Semi-monthly	☐
Is spouse claimed on someone else's taxes as a dependent?						☐ Yes	☐ No		
Spouse's Gross Monthly Salary:									

DEPENDENT INFORMATION (if more than 6 use separate page)				
Full Name: (first, middle, last)	Date of birth:	Relationship:	Claimed on taxes?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

TOTAL INCOME INFORMATION (enter monthly amounts)					
Gross Wages: $		Worker Comp: $			
Pension/Retirement:$		Unemployment: $		Misc.: $	
Rental Income: $		Alimony/Child Support: $			
Veterans Benefits: $		Interest/Dividends: $			
Short/Long Term Disability: $		SSI/SSDI Social Security: $			

PROPERTY INFORMATION			
Type:	Monthly Payment:	Estimated Value:	Unpaid Balance:
Primary home			
2nd mortgage			
Secondary/Vacation home			
Rental property			
Land			

AUTO/MOTORCYCLE/RV/BOAT/JET SKI/TRAVEL TRAILER/ETC INFORMATION			
Type/Make/Model/Year:	Monthly Payment:	Estimated Value:	Unpaid Balance:

MONETARY ASSET INFORMATION					
Checking Balance $		Savings Balance $			CD $
Stocks/Bonds $		IRA $		401k $	
403b $		Others (HSA/FSA) $			

Certification: By signing below, I certify that the all of the preceding information is true and correct. I understand that this information may be reviewed in conjunction with a credit report, and I further understand that if I knowingly provide untrue information in the application, I will be ineligible for financial assistance and any financial assistance granted to me may be reversed and I would be responsible for the medical bills.

Guarantor Signature:		**Date:**	
Spouse (if applicable):		**Date:**	

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Instructions for Financial Assistance Application

Please complete the Financial Assistance Application and attach copies of each of the following:
(please be aware that it is important that you send photo copies of these documents and not the originals, as we are unable to return original documents to you)

- Two most recent paystubs from your current employer(s)
- Two most recent paystubs from your spouse's (if applicable) current employer(s)
- Two most recent bank statements from all checking and savings accounts owned by you and/or your spouse
- Last Year's Federal Tax Return (if you did not file taxes, please explain why in the letter space provided below) Recent 401k/Retirement/CD/etc. Statements
- Most recent Unemployment Benefit Statement
- Most recent Property Tax Statement
- Most recent Social Security/Disability Benefit Letter
- Most recent Mortgage Balance Statement
- If not working and you depend on help from others for basic living needs, please provide a letter from those that are helping you, explaining how they have assisted you
- If you rely on student loans for living expenses, please provide proof of 2 most recent semester loan allocations
- If patient is not a US Citizen, but is a Permanent Resident, please provide a copy of their US Resident Card

Please write a letter in the space provided below, to 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)

Guarantor Signature:		Date:	