RANSOM MEMORIAL HOSPITAL

RMH FINANCIAL ASSISTANCE APPLICATION REQUIREMENTS

Please return your Ransom Memorial Hospital (RMH) Financial Assistance Application with all the information noted within the application.

If you should have questions or need assistance completing or understanding the application requirements please feel free to call **Melissa @ 785-229-8247.**

Please sign, date and return your completed application with all required supporting documentation to the Business Office of Ransom Memorial Hospital @ 901 S Main Street, Po Box 460, Ottawa, Kansas 66067.

Only complete applications, with all required supporting documentation included, Will be processed.

Ransom Memorial Hospital Business Office

901 S Main Street

Po Box 460

Ottawa, Kansas 66067

Ransom Memorial Hospital Financial Assistance Application

Name of Patient:_____SSN:_____

Name of Spouse/Domestic Partner: _____SSN:_____

Name of person responsible for the bill: _____

Number of dependents (anyone under 18 living with you):_____Phone number: _____

Address: _____City: _____State: _____Zip: _____

Employer: _____Phone number: _____

Employer address: _____

Spouse's Employer: _____Phone number: _____

Employer address: _____

Monthly Household Income: Income includes wages, annuities, social security, retirement benefits, unemployment, worker's compensation, child support or alimony. This list is not all inclusive:	
Source	Amount
	$
	$
	$

Note: If you report $0 income you are <u>required</u> to provide below a brief explanation of how you (or the patient) are surviving financially (please feel free to utilize the back of this form for additional space):

_____
_____
_____
_____
_____
_____
_____

Ransom Memorial Hospital Financial Assistance Application

Liquid Assets:	Name of Institution:		Balance:
Checking Account:			
Savings Account:			
Other:			
Other Assets:	$ Value:	$ Owed:	$ Equity Balance:
Home:			
Rental Property:			
Farm:			
Automobile(s)			
Liability – Rent			
Name of Landlord:	Address:		Monthly Rent:
Other Liabilities:			
Utilities:	Average Monthly Payment:		
Gas:	$		
Water/ Electric	$		
Telephone/Cable:	$		
Other: Please Specify:	$		
	$		

Other Liabilities:		
Credit Card Name:	Payment:	Balance:
	$	$
	$	$
	$	$
	$	$
Other Debts:		
To Whom Owed:	Payment:	Balance:
	$	$
	$	$
	$	$
	$	$

Before your application can be processed, you must provide the following documentation to our Ransom Memorial Hospital Business Office Account Representative:

_____ Completed dated and signed Ransom Memorial Hospital Financial Assistance Application.

_____ W-2 withholding statements for all employed members living at home.

_____ **Most recent** federal/state income tax returns for all members living at home. We must receive **ALL** pages of your return, not just page 1.

_____ Paycheck, Social Security, Pension, Disability or Unemployment check stubs for the **past three months**. If you do not have check stubs then you are required to provide a written statement documenting monthly earnings from your Employer(s), or documentation from the State and or Federal Program or other source for which you receive compensation.

Ransom Memorial Hospital Financial Assistance Application

_____ Forms approving or denying unemployment/workers compensation.

_____ Denial received from SRS-State of Kansas Medicaid program.

_____ **Complete** checking account and/or savings account statements **(past 3 months)**

_____ 1 statement of a bill listed on the application (gas, water, etc.) We only need 1 bill for 1 month, **not** all your bills and **not** for 3 months and **NO** hospital bills.

I hereby certify that I am of legal age and that the foregoing statements are true and complete and are made for the purpose of determining my eligibility for the Ransom Memorial Hospital Financial Assistance Application. I agree that this statement shall remain hospital property, whether or not the application is accepted. I agree to provide all required information. I authorize you to make all inquiries that you deem necessary to verify the accuracy of the statements made herein. I understand that if I give any false information in this application, I will be denied the Sharing Program and the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Further, I will make application for any Assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for Hospital charges.

Furthermore, I understand RMH may access and utilize my credit report in making a decision related to Ransom Memorial Hospital Financial Assistance Application.

Applicant's Signature: _____

Spouse's Signature: _____

Date: _____

(OFFICE USE ONLY)

Date Application Received: _____Income Verified: _____

Credit Verified: _____Employment Verified: _____

Date of Determination of Eligibility: _____Approved/Disapproved: _____

Rec'd by: _____Date Applicant Notified: _____

Signature of Processing Financial Counselor: _____