Sumner Regional Medical Center
1323 North “A” Street
Wellington, KS 67152
(620) 326-7451

Financial Assistance Application 2010

Our Mission:

Through the commitment of our employees, providers and the community; we will continuously exceed the expectations of our patients, families, visitors, and co-workers for quality, compassion, service, and value.

Required Documentation:

To help us evaluate your application, please provide the following documents.

- Wages, Salaries, and Commissions (W-2, 1099, etc.)
- Checking & Savings account statements (2 months prior and 2 months following date of service)
- Most recent Federal & State tax returns.

Guidelines:

Sumner Regional Medical Center is pledged to providing necessary medical care routinely available at the hospital to all residents of the City of Wellington, and surrounding areas, regardless of ability to pay. In fulfilling this pledge, the Board of Trustees and Administration have developed guidelines to uniformly evaluate requests for financial assistance. Sumner Regional Medical Center and Administration reserve the right to make the final determination regarding the type or amount of financial assistance to be provided based upon all available information. It is the responsibility of the applicant to provide all information requested in this application. Any application, which is believed to be incomplete or contain false and misleading information, may be denied or delayed.

Individuals and their legal dependents whose income, liquid assets and other assets which are not necessary for reasonable health and well-being, fall below the guidelines set out by the Hospital will be considered for the level of financial assistance they fall into once this application is reviewed. In making the determination, Sumner Regional Medical Center will allow the deduction of certain extraordinary losses from income. Examples of losses which Sumner Regional Medical Center is willing to consider on a case by case basis might be medical bills, prescription drug charges and casualty losses that are not reimbursed by insurance. Current rates and considerations can be discussed with the financial counselor.

Financial Assistance Application 2010

Patient Demographics:

Name: ____
First Middle Last

Address: ____
Street City State Zip

Phone: (_______) _______-___________ Years at this Address: ___________

Previous Address: ______________________________________
Street City State Zip

Soc. Sec. #: _______-_____-_________ Marital Status: Single / Mar / Wid / Div / Sep.

Veteran: Y / N Date of Birth: _______-_______-_______ Age: _______

Responsibly Party: (If other than patient)

Name: ____
First Middle Last

Address: ____
Street City State Zip

Phone: (_______) _______-___________ Years at this Address: ___________

Previous Address: ______________________________________
Street City State Zip

Soc. Sec. #: _______-_____-_________ Marital Status: Single / Mar / Wid / Div / Sep.

Veteran: Y / N Date of Birth: _______-_______-_______ Age: _______

Dependents & Others in Household:

Name:	Age:	Relation:	Employer:	Income:

Please fill out employment information for yourself, and spouse, also list second jobs if applicable.

Employment Information:

Company: ____

Address: ____
Street City State Zip

Phone: (_______) _______-____________ Job Title: ______________________________

Wage/Earnings: ________________ Wk / Mo / Yr

Deductions: ____________________ Wk / Mo / Yr Description: ___________________________

(Example: Individual Retirement Account / Tax Shelter Annuity / Other Deduction)

Employment Information:

Company: ____

Address: ____
Street City State Zip

Phone: (_______) _______-____________ Job Title: ______________________________

Wage/Earnings: ________________ Wk / Mo / Yr

Deductions: ____________________ Wk / Mo / Yr Description: ___________________________

(Example: Individual Retirement Account / Tax Shelter Annuity / Other Deduction)

Employment Information:

Company: ____

Address: ____
Street City State Zip

Phone: (_______) _______-____________ Job Title: ______________________________

Wage/Earnings: ________________ Wk / Mo / Yr

Deductions: ____________________ Wk / Mo / Yr Description: ___________________________

(Example: Individual Retirement Account / Tax Shelter Annuity / Other Deduction)

Please use back side of this sheet for any additional employment information. Thank you.

Health Insurance Information:

Do you have insurance? Y / N Does your employer offer insurance? Y / N

Insurance information:

Insurance Company: ______________________________ Group #: ________________________

Policy #: ___________________________________ Insured: ______________________________

Financial Resources: (Personal & Household)

Do you own any of the following:

A Home: Purchase $: ____________ Mortgage $: ____________ Date: _________

Rental Prop. Purchase $: ____________ Mortgage $: ____________ Date: _________

Assets:

Cash on Hand: $ _______________

Checking Account: $ _______________ (Provide Statement)

Savings Account: $ _______________ (Provide Statement)

Time Certificates: $ _______________ (Provide Statement)

Stocks/Bonds: $ _______________ (Provide Statement)

Estate/Trust: $ _______________ (Provide Statement)

Coins/Precious Metal/ Gems: $ _______________

Collectibles: $ _______________

Other: ____________________ $ _______________

Other Assets: (Automobiles, Machinery, Boats, Cattle, Etc.)

Item:	Year:	Value:	Debt:

Other Income: (In Dollar Amount)

Unemployment: $____________Wk

Social Security: $____________Mo

SSI: $____________Mo

Alimony: $____________Mo

Pension: $____________Mo

Dividends: $____________Qtr

Disability: $____________Mo

Rent: $____________Mo

Workers' Comp.: $____________Mo

Railroad Retirement: $____________Mo

Veteran's Benefits: $____________Mo

Child Support: $____________Mo

Interest: $____________Mo

Annuity: $____________Mo

Estate/Trust: $____________Mo

Other____________: $____________Mo

Other Assistance:

	Applied:	Approved:	Amount:	Recipient:
Soc. Sec. Disability:				
A.D.C.:				
Medicaid (Title XIX):				
Food Stamps:				
Utility Assistance:				
Other:				
Other:				

Medical Bills & Extraordinary Losses:

Creditor:	Amount:	Date:	Explanation:
Sumner Regional Medical Center	**$**		
	$		
	$		
	$		

ATTENTION:

I (we) request that Sumner Regional Medical Center consider this application for financial assistance with my (our) debts for the services provided by Sumner Regional Medical Center. I (we) also certify that the information on this application as well as all supporting documentation is complete and accurate. Approval for financial assistance is dependent on my (our) satisfactory payment of amounts deemed payable by me (us).

Signed: ____ Date: ____/_____/_______

Signed: ____ Date: ____/_____/_______

Spouse / Parent / Legal Guardian