If you would like to be considered for Charity Care, please complete this financial assistance form. Below are the guidelines that you must follow in order to qualify for charity write-off:

1) Please complete the entire charity form.

2) Please send a copy of your state and federal income tax returns. If you do not file taxes, proof of income is necessary, whether it be a copy of your most recent W-2 or an alternative form that provides your most recent proof of income.

3) Please start making payments on the account. There needs to be at least six months or more of documented effort to pay.

4) Please make sure all family dependents living with you are listed, including social security numbers and dates of birth.

5) Any accounts turned to a collection agency will not qualify for financial assistance, as there has been no effort to make payments toward the balances owed CRMC.

If you need assistance with this application, please call the number shown below.

Thank you,
Patient Account Representative
(816) 649-3326

CAMERON REGIONAL MEDICAL CENTER DATE:_____

APPLICATION FOR FINANCIAL ASSISTANCE

THE INFORMATION REQUESTED ON THIS APPLICATION WILL BE USED TO ASSIST IN DETERMINING ELIGIBILITY. APPLICANT WILL BE REQUIRED TO SHOW PROOF OF INCOME AND EXPENSES. APPLICATION MUST BE COMPLETE. DEPENDENTS ARE CHILDREN AND OTHER DEPENDENTS WHO ARE LIVING WITH THE APPLICANT AND ARE CLAIMED AS DEPENDENTS ON FEDERAL AND STATE INCOME TAX FILINGS.

PATIENT: _____ ACCOUNT NO. _____ AGE _____ DATE OF ADMISSION _____

RESPONSIBLE PARTY OR APPLICANT	AGE	SOCIAL SECURITY #	SPOUSE	CHILDREN OR DEPENDENTS No. and Ages	

FAMILY MEMBERS LIVING IN YOUR HOME	DATE OF BIRTH	SOCIAL SECURITY #

ADDRESS _____ HOW LONG @ ADDRESS _____ TELEPHONE NUMBER _____

	EMPLOYER	POSITION	HOW LONG THERE FROM	TO	MONTHLY GROSS INCOME	TAKE HOME EACH CK	TAKE HOME MONTHLY
1.							
2.							

LIST SOURCES OF OTHER INCOME

IF RESPONSIBLE PARTY OR SPOUSE IS EMPLOYED, HOW LONG EMPLOYED? WHO WAS PREVIOUS EMPLOYER? OCCUPATION?

1. _____
2. _____

MONTHLY INCOME BEFORE TAXES $_____ MONTHLY TAKE HOME PAY $_____ NAME OF BANK_____

POSSIBLE SOURCES OF OTHER INCOME

Alimony	Retirement
Annuity Payments	Social Security
Child Support	Trusts
Dividends	Workman's Comp
Interest	Public Assistance
Rent	

POSSIBLE SOURCES OF PAYMENT

County Indigent Funds
Auto Medical Insurance
Settlement of Liability Claims

Checking _____
Savings _____

A. MONTHLY INCOME BEFORE TAXES $_____gross X 12 $_____ No. in family_____

B. MONTHLY TAKE HOME PAY $_____net x 12 $_____

A. Hill Burton Guidelines $_____

B. Per Capita Income Guidelines $_____

IF APPLICANT QUALIFIES FOR CHARITY BASED ON INCOME GUIDELINES
ADDITIONAL INFORMATION NOT REQUIRED EXCEPT FOR APPLICANTS SIGNATURE
TRANSFER REQUIRED INFORMATION TO SUMMARY.

FOOD (Monthly Cost)	$_____	UTILITIES (Monthly Cost)		BUYING/OWN_____	APARTMENT_____
Grocery Store	$_____	Electric	$_____	RENT_____	MOBILE HOME____
Lunches - work	$_____	Gas	$_____	_____Furnished	HOUSE_____
Lunches - school	$_____	Water	$_____	_____Unfurnished	
Restaurant Meals	$_____	Phone	$_____	Rent.Mtg Payment of $_____	____%of take home pay
% of Take Home Pay Total	$_____	Total	$_____	Paid To _____	

TRANSFER REQUIRED INFORMATION TO SUMMARY

I UNDERSTAND THAT THE INFORMATION SUBMITTED IS SUBJECT TO VERIFICATION BY THIS HOSPITAL. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. IF ANY INFORMATION I HAVE GIVEN PROVES TO BE UNTRUE, I UNDERSTAND THAT THE HOSPITAL MAY RE-EVALUATE MY FINANCIAL STATUS AND TAKE WHATEVER ACTION BECOMES NECESSARY.

_____ _____ _____
SIGNATURE OF APPLICANT DATE SIGNATURE OF WITNESS

PROVISIONAL DIAGNOSIS

	MONTHLY PMTS	PAID TO	DATE DEBT INCURRED	ITEM PURCHASED
auto year/make				
auto year/make				

LIST ANY MONTHLY PAYMENTS TO THE RIGHT

INSURANCE BENEFITS

REMINDERS
CREDITORS

CREDIT CARDS
BANKS
HOSPITALS
FINANCE COMPANY
DOCTORS
DEPT STORES
CREDIT UNION

← total pmts_____% of take home pay total →

balance

SUMMARY

		Percent of Take Home Pay
Take Home Pay	$_____	
Rent/Mtg	$_____	_____%
Utilities	$_____	_____%
Food	$_____	_____%
Monthly Pmts	$_____	_____%
Balance of take home pay left for: Auto repairs, gas & oil, clothing, medical, personal, education, entertainment, misc	$_____	_____%
		_____% TOTAL

CIRCUMSTANCES FOR CONSIDERATION
PLEASE GIVE A BRIEF REASON WHY YOU NEED ASSISTANCE

	ANNUAL FAMILY INCOME	NO. IN FAMILY	INCOME GUIDELINES
A.	$_____		
B.	$_____		

DATE **SIGNATURE OF PERSON TAKING APPLICATION**

OFFICE USE ONLY

EMPLOYMENT STATUS_____
INFORMATION
VERIFIED NO_____ YES_____ HOW? _____
CREDIT REPORT NO_____ YES____

REASON FOR APPROVAL
____ 95020 INCOME GUIDELINES MET
____ 95021 UNEMPLOYED
____ 95022 DEBT OVERLOAD
____ 95023 CATASTROPHIC MEDICAL BILLS
____ 95024 EXPIRE, NO ESTATE
____ 95025 40/48 BALANCE
____ 95026 OTHER _____

REASON FOR DENIAL
_____ INCOMPLETE INFORMATION
_____ LACK OF COOPERATION
_____ SUFFICIENT INCOME APPARENT
OTHER

BILLED CHARGES ____
THIRD PARTY PAYMENTS ____
PAID BY RESPONSIBLE PARTY ____
BALANCE ____
APPROVED FOR CHARITY ____

_____ DATE _____ APPROVED

_____ DATE _____ APPROVED