FINANCIAL APPLICATION

Please complete this financial application and include income and other supporting documentation as appropriate. This documentation is required in order to process your application. If the application and all required supplements are not received by the due date below, your application may not be considered

ACCOUNT(S)

DATE SENT **DATE DUE**

INFORMATION

PATIENT NAME	SSN	DOB	MARITAL STATUS S M D W	PHONE
GUARANTOR NAME	SSN	DOB	RELATIONSHIP TO PT.	PHONE
SPOUSE NAME	SSN	DOB	PHONE	
STREET ADDRESS	CITY		STATE	ZIP

PREVIOUS EMPLOYER (PATIENT OR GUARANTOR)	LAST DATE EMPLOYED	PLEASE SELECT ONE: ☐ RENT ☐ OWN	HOUSEHOLD SIZE ADULTS _____ CHILDREN _____
CURRENT EMPLOYER (PATIENT OR GUARANTOR)	PHONE	CURRENT EMPLOYER (SPOUSE)	PHONE
ADDRESS / CITY / STATE / ZIP		ADDRESS / CITY / STATE / ZIP	
POSITION OF TITLE	LENGTH OF EMPLOYMENT	POSITION OR TITLE	LENGTH OF EMPLOYMENT
GROSS INCOME: ☐ WKLY. ☐ BIWKLY. ☐ SEMI-MNTLY. ☐ MNTLY.		GROSS INCOME: ☐ WKLY. ☐ BIWKLY. ☐ SEMI-MNTLY. ☐ MNTLY.	

PATIENT'S OR GUARANTOR'S MONTHLY INCOME

WAGES	SOCIAL SECURITY INCOME
PENSION	RENTAL INCOME
ALIMONY/CHILD SUPPORT	OTHER (INCL. FOOD STAMPS/TANF)

SPOUSE'S MONTHLY INCOME

WAGES	SOCIAL SECURITY INCOME
PENSION	RENTAL INCOME
ALIMONY/CHILD SUPPORT	OTHER (INCL. FOOD STAMPS/TANF)

MONTHLY EXPENSES

RENT/MORTGAGE/PROP. INS.	FOOD	AUTO INSURANCE	CHILD CARE
UTILITIES	HOUSEHOLD SUPPLIES	AUTO FUEL/MAINTENANCE	ALIMONY/CHILD SUPPORT
TELEVISION/PHONE/INTERNET	MEDICAL EXPENSES	OTHER (PLEASE SPECIFY)	

CREDITOR	PAYMENT	BALANCE	CURRENT?	CREDITOR	PAYMENT	BALANCE	CURRENT?
CREDITOR	PAYMENT	BALANCE	CURRENT?	CREDITOR	PAYMENT	BALANCE	CURRENT?
CREDITOR	PAYMENT	BALANCE	CURRENT?	CREDITOR	PAYMENT	BALANCE	CURRENT?

TOTAL MONTHLY INCOME	TOTAL MONTHLY EXPENSES	DIFFERENCE

PATIENT AGREEMENT

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining financial assistance. The undersigned authorizes the release of necessary medical and financial information to obtain third-party coverage and/or to obtain replacement pharmaceuticals from the appropriate drug company programs on their behalf. The original or a copy of this application will be retained by Bothwell Regional Health Center, even if the financial assistance is not granted. Falsification of information on this application is grounds for disapproval. I understand that Bothwell Regional Health Center may request a credit bureau report in the process of evaluating my application for financial assistance.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF RESPONSIBLE PARTY OR SPOUSE DATE

REQUIRED SUPPLEMENTAL DOCUMENTATION

When submitting this application, please also provide one [or more, when applicable] of the following documents as verification of household income:

- Copy of IRS Form 1040 and all applicable Schedules (C, E, F, etc.) from most recent tax year
- Copy of W-2 from most recent tax year for each working adult in the household
- Copy of Social Security Benefit Verification Letter from most recent tax year for each person receiving Social Security Benefits
- Statement of weekly unemployment benefits
- Copies of paystubs from most recent three months for each working adult in the household

Please note that, when available, the most recent federal tax return is always the preferred means of income verification.

You may be required to provide:

- Proof of application for MO HealthNet or other state Medicaid benefits, and denial of such application
- Proof of application for commercial insurance through the Health Insurance Marketplace, and proof of exemption from enrolling in coverage as legally required

ADDITIONAL CONSIDERATIONS

Applications for financial assistance shall only be considered if the patient does not have health insurance and does not qualify for a governmental health care program.

This application is only valid for services performed and charges incurred at Bothwell Regional Health Center and BRHC Clinics.

Once we receive your documentation, we will review your application for full or partial financial assistance. If you do not need financial assistance or do not qualify, but still can not pay off your account balance within BRHC's pre-determined payment guidelines, we will consider this application for our extended payment program.

If approved, your application will be valid for six (6) months for charges incurred as a result of medically necessary and/or urgent visits, and we will consider additional BRHC accounts as subject to such approval for financial assistance during that period of time. If you are currently subject to a payment plan, we will re-evaluate your payment plan upon addition of other charges in order to ensure that payments remain appropriate in relation to both the agreement and the balance.

A Patient Financial Services Representative will notify you of the approval or disapproval of this application in writing. All of your information is kept confidential according to the strict protective guidelines of Bothwell Regional Health Center.

PAYMENT PLAN GUIDELINES

Payments must be a minimum of $50 every month, with a maximum allowance of thirty-six (36) months to pay the account in full. Please note that, if a payment is not received each month and no prior arrangement is made, the account may be considered delinquent and subject to further collection action.

Patient Financial Services
601 East 14th Street
Sedalia, Missouri 65301
(660) 826-8833

MRN **Patient Name**

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the release of information regarding the status of any Medicaid application/case to Bothwell Regional Health Center. This authorization is limited to:

- The status of the Medicaid application/case (pending, approved, rejected), and/or
- The spend-down amount and/or remaining liability of my Medicaid case.

This authorization expires upon notification to Bothwell Regional Health Center of the determination of my eligibility for Medicaid.

A Member of the Family Support Division, in written or verbal form, shall release this information for the sole purpose of assisting Bothwell Regional Health Center in billing Medicaid for medical expenses incurred.

I (we) hereby release the Family Support Division from any liability for information furnished pursuant to this authorization.

SIGNATURE OF CLIENT DATE

SIGNATURE OF SPOUSE DATE

SIGNATURE OF OTHER DATE

CASE NAME CASE NUMBER

CASE WORKER NAME LOAD NAME