Financial Assistance Application

North Kansas City Hospital

PART A – PATIENT INFORMATION

Last Name _____ First Name _____ Birthdate _____ SSN _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status: ☐ Single ☐ Live-In Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do any of your dependents have any North Kansas City Hospital accounts that need to be considered within this application? ☐ Yes ☐ No

Please list all encounter numbers, including any applicable dependent accounts:

ACCOUNT NAME (PERSON ON THE ACCOUNT)	ENCOUNTER NUMBER

PART B – RESPONSIBLE PARTY INFORMATION

Examples include: spouse, live-in partner, parent, guardian, guarantor, etc. **If same as patient, skip Part B.**

Last Name _____ First Name _____ Relationship to Patient _____

SSN _____ Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

PART C – DEPENDENTS

List all dependents who reside in the applicant's home **for whom the applicant takes financial responsibility**.
Check the appropriate relationship box for each dependent. **Attach an additional sheet if necessary.**

NAME	AGE	SPOUSE/PARTNER	PARENT	CHILD (UNDER 21)	OTHER

Number of people in household: _____ Number of children under age 21 in the home: _____

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PART D – HOUSEHOLD INCOME & ASSETS

Monthly Gross (last 30 days)

Source of Income	Patient/Applicant	Spouse/Live-in Partner	Asset Type	Patient/Applicant	Spouse/Live-in Partner
Gross Wages/Salary	$	$	If owned, value of house	$	$
Social Security Benefit	$	$	Loan balance	$	$
Disability Benefit	$	$	Other property, value	$	$
Unemployment Benefit	$	$	Loan balance	$	$
State Assistance	$	$	Stocks/Bonds	$	$
Alimony/Child Support	$	$	Certificate of Deposit (CD)	$	$
Rental or Business Income	$	$	IRAs/Retirement Fund	$	$
Student Loans/Grants	$	$	Checking/Savings Account(s)	$	$
Other	$	$	Investment Account(s)	$	$
Total Income	$	$	Total Assets	$	$

If income is $0, please check all that apply:

☐ Lives with relative(s) ☐ Lives with friend(s) ☐ Retired ☐ Unemployed ☐ Disabled ☐ Homeless ☐ Student

Other: _____

PART E – OTHER MEDICAL OBLIGATIONS AND SPECIAL CIRCUMSTANCES

List all medical-related expenses outstanding (exclude NKCH).

NAME OF BILL	BALANCE OWED	MONTHLY PAYMENT

If you have special circumstances you would like considered, please attach a separate letter with an explanation.

☐ I have attached a separate letter.

PART F – DOCUMENTS

Please attach copies of the following documents:

1. Most recent income tax return
2. Bank statements for the last two months
3. Pay stubs for the last two months or Social Security/Disability Benefit letter

If unable to provide such documentation, please contact a Resource Counselor (816.691.2598) to discuss other evidence that may be provided to demonstrate eligibility.

PART G – SIGNATURE

By my signature below, I certify the above information is an accurate and complete statement of my current financial position and give my permission to verify this information.

Signature of Patient/Responsible Party _____ Date _____