Children's Mercy

Children's Mercy Financial Assistance Application

Not Part of a Medical Record

8241-072 (06/16)

Some key requirements to be eligible for financial assistance are:

1. You must be a resident in the state of Kansas or Missouri.
2. You have a household income (adjusted for family size) of less than or equal to 300% of Federal Poverty guidelines.
3. You must have used all your resources from all other programs (including Medicaid).
4. Completion of an application does not mean you will receive a discount.

You will need to:

- Complete this application and return it to a Financial Counselor, along with all other documents noted in the checklist on Page 2.
- Please allow up to 3 weeks for your application to be processed.

To discuss payment arrangements, please contact Patient Financial Services at 816-701-5100 or toll free at 866-572-0157

MAIL completed application to:	Children's Mercy Hospital Attn: Financial Counseling Department 2401 Gillham Rd Kansas City, MO 64108

FAX: (816)302-9907 For faxing, please use this page as your cover sheet and write in:

_____ _____ _____

Your Name Your phone# # of pages

The following documentation must be included for us to process your application:

- ☐ **Picture identification** for the Responsible Party (driver's license or state identification)
- ☐ **Residency verification** with current address (recent utility bill, state ID, tax returns, check stubs)
- ☐ **Most recent Income Tax Return**
- ☐ **Copy of last 3 months of pay check stubs** or a statement of wages on company letter head, signed by your employer(s)
- ☐ For families without any income, a signed and dated statement of who provides food and shelter
- ☐ For non-US citizens, identification documents (birth certificate, visa, permanent residency card)
- ☐ Documentation for any other forms of income not on current Income Tax Returns

For further questions or information:

- Email: admfc@cmh.edu
- Call: 816-234-3567
- Find more information online at www.childrensmercy.org/financialcounseling/OR
- Visit with a Financial Counselor at one of our locations (Mon-Fri, 9am-5pm):

Children's Mercy, Adele Hall Campus
2401 Gillham Rd, Kansas City, MO 64108

Children's Mercy Hospital Kansas
5808 W 110th, Overland Park, KS 66211

Children's Mercy Clinics on Broadway
3101 Broadway Blvd, Kansas City, MO 64111

APPLICATION FOR FINANCIAL ASSISTANCE

TODAYS DATE: _____/_____/_____
Month Day Year

RESPONSIBLE PARTY:

The **"Responsible Party"** is the patient or patient's legal guardian who is financially responsible for services provided by Children's Mercy.

_____ _____
Last First MI SSN

_____ _____
Relationship to Patient(s) Home Address City State Zip

(____)_____ (____)_____ _____
Primary Phone Secondary Phone Employer

_____ _____ _____/_____/_____ Stepparent? ☐
Occupation Years Employed Date of Birth

OTHER RESPONSIBLE PARTY IN HOUSEHOLD *(if applicable):*

_____ _____ Stepparent? ☐
Last First MI SSN

_____ _____ _____ _____/_____/_____
Employer Occupation Years Employed Date of Birth

PLEASE LIST ALL PERSONS IN YOUR HOUSEHOLD BELOW (including Responsible Party(ies)

Last First	Date of Birth:	Relationship to patient(s):	Name of Insurance Plan:	US Citizen? Yes/No
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				--
				--
				--
				--
				--
				--
				--

HOUSEHOLD INCOME:
"Household income" is income for the Responsible Party and all individuals residing in the household as claimed on the Responsible Party's federal income tax return.

Item	Monthly Amount	Whose income?
☐ Salary and Wages	$_____	_____
☐ Unemployment Compensation	$_____	_____
☐ Workers' Compensation	$_____	_____
☐ Social Security and/or Supplemental Security Income	$_____	_____
☐ Public Assistance Payments	$_____	_____
☐ Veteran's Payments or Survivor Benefits	$_____	_____
☐ Pension or Retirement Income	$_____	_____
☐ Alimony or Child Support	$_____	_____
☐ Interest, Dividends, Rents, Royalties	$_____	_____
☐ Income from Estates or Trusts	$_____	_____
☐ Educational Assistance	$_____	_____
☐ Other Income	$_____	_____
TOTAL MONTHLY INCOME:	**$**_____	

HOUSEHOLD ASSETS:
"Household Assets" include information on funds readily available to the Responsible Party and all individuals residing in the household as claimed on the Responsible Party's federal income tax return. Assets such as retirement funds, land, buildings, and vehicles are excluded and should not be reported below.

Item	Current Balance
☐ Checking Account	$_____
☐ Savings Account	$_____
☐ Stocks and/or Bonds	$_____
☐ Lump Sum Payments	$_____
☐ Other Assets	$_____
TOTAL CURRENT VALUE:	**$**_____

OTHER CONSIDERATIONS:

Have you applied for Medicaid? -- Date applied:_____ Outcome:_____

Was your treatment at the Hospital due to an accident (auto, work related, crime victim)? --

RESPONSIBLE PARTY EXPLANATION, REQUEST, AND ADDITIONAL INFORMATION:

Please use this section to explain any circumstance that makes payment of your financial responsibility a financial hardship. Please also provide any other information that you feel would be helpful in reviewing your request for assistance. You may also wish to attach additional documentation that may support your application.

If I am approved for financial assistance, The Children's Mercy Hospital reserves the right to reverse this discount should any third party payer or carrier pay on my account(s) partially or in its entirety. I understand that it is my responsibility to report to the Hospital, within 30 days, any change in my Household Income or other factors that may impact eligibility for financial assistance from the Hospital. I certify that the information given on this application and any attached supporting documentation is accurate and complete to the best of my ability. Should the Hospital become aware of any misrepresentation, I understand that any discount received will be reversed and I will be responsible for any remaining balance(s). I authorize the Hospital to investigate the information in reviewing my application for financial assistance and authorize the release of any information necessary to determine my eligibility.

Signature of Patient/Parent/Legal Guardian	Relationship	Date

Signature of Patient/Parent/Legal Guardian	Relationship	Date

OFFICE USE ONLY

Percent of FPL: _____ Approved/Denied:_____ Date:_____

Financial Counselor: Printed Name:_____ Signature:_____

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