



# Children's Mercy

HOSPITALS & CLINICS

www.childrens-mercy.org

Financial Assistance Application

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8241-072 MR 06/11

## INSTRUCTIONS:

1. The Children's Mercy Hospital offers a discount program for patients not eligible for other assistance programs. If it is determined that eligibility exists for other programs, applications for such programs must be completed before this application can be processed.
2. Information provided on the application must include the Responsible Party and all other individuals residing in the same household as the Responsible Party. The Responsible Party is a patient or the patient's parents (birth or adoptive), stepparents, legal guardian, or other individual who is legally responsible for payments to the Hospital for health care services provided to the patient. Unless otherwise approved through the Admissions department, the Responsible Party is the individual with whom the patient resides.
3. Incomplete applications will not be considered for assistance.
4. **Attach proof of residency (driver's license, utility bill, etc.).**
5. **Attach proof of patient's citizenship (birth certificate, permanent residency card, etc.).**
6. **Attach a copy of your most recent income tax return, the three (3) most current months of pay check stubs or a statement of wages on company letterhead signed by your employer(s), and any other documentation to support Household Income listed below.**
7. If you have questions or need help completing this application, please call a financial counselor at (816) 234-3567.

**Please complete and mail WITHIN 15 DAYS to:**

**Children's Mercy Hospitals and Clinics  
 ATTN: Admissions Department  
 2401 Gillham Road  
 Kansas City, MO 64108**

### Section 1: Family and Household Size

Complete for the Responsible Party and those individuals residing in the same household as the Responsible Party who are claimed on the Responsible Party's federal income tax return.

Complete Name of Father or Guardian ↓

Stepfather?  Yes  No

_____	_____	_____	_____
Last	First	Middle	Social Security Number

_____	(____) _____ - _____	(____) _____ - _____
Relationship to Child(ren)	Home Phone	Work Phone

_____	_____	_____	_____
Home Address	City	State	Zip

_____	_____	_____
Employer's Name	How Long Employed	Occupation

Complete Name of Mother or Guardian ↓

Stepmother?  Yes  No

_____	_____	_____	_____
Last	First	Middle	Social Security Number

_____	(____) _____ - _____	(____) _____ - _____
Relationship to Child(ren)	Home Phone	Work Phone

_____	_____	_____	_____
Home Address	City	State	Zip

_____	_____	_____
Employer's Name	How Long Employed	Occupation



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**PLEASE LIST ALL PERSONS IN YOUR HOUSEHOLD BELOW:**

Last	First	Date of Birth	Insurance/Medicaid/ Other Information	OFFICE USE – MR #
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		
		/ /		

**Section 2: Household Income**

Income verification is required in order to process all applications. This section should include income for the Responsible Party and all individuals residing in the household as claimed on the Responsible Party's federal income tax return. Attach a copy of your most recent income tax return, the three (3) most current months of pay check stubs or a statement of wages on company letterhead signed by your employer(s), and any other documentation to support Household Income listed below.

**HOUSEHOLD INCOME INFORMATION:**

Please indicate below the amount your household receives each month for each of the following items. This information is needed to help us determine the amount of possible discount you may receive.

Item	Monthly Amount
_____ 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 Including Assistance from Outside the Household	\$ _____
<b>TOTAL MONTHLY INCOME (Will be added by financial counselor.)</b>	<b>\$ _____</b>



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### Section 3: Asset Information

This section should 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	\$ _____
_____ CD and/or Money Market Funds	\$ _____
_____ Stocks and/or Bonds	\$ _____
_____ Lump Sum Payments	\$ _____
_____ Other Assets	\$ _____
<b>TOTAL CURRENT VALUE (Will be added by financial counselor.)</b>	<b>\$ _____</b>

### Section 4: Other Information

- Do you have health insurance coverage?  Yes  No  
If Yes, Name of Coverage Provider: \_\_\_\_\_ Policy Number: \_\_\_\_\_
- Were any of the services necessary because of an accident?  Yes  No
- Are either the patient or Responsible Party eligible for any of the following?  
 Women, Infants and Children (WIC) Program  Food Stamps  Subsidized School Lunch Programs
- Is any household member receiving free health care services from any of the following community providers?  
 Kansas City Free Health Clinic  Swope Health Services  Samuel U. Rodgers  Cabot Westside  
 Other: \_\_\_\_\_

### **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.

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**PLEASE READ AND SIGN BELOW:**

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 the Hospital will reverse any discount that is given if other payments are received. 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. I furthermore authorize the release of any information necessary to determine my eligibility for financial assistance or for auditing purposes including to external sources that may provide funds or designated auditors.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Father/Guardian Relationship Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature of Mother/Guardian Relationship Date

**OFFICE USE ONLY**

Percent of FPL Guidelines: \_\_\_\_\_

Financial Counselor: Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Committee Approval (if applicable):

Committee Chair (or Designee): \_\_\_\_\_ Date: \_\_\_\_\_

Second Committee Member: \_\_\_\_\_ Date: \_\_\_\_\_