

Financial Assistance Application

Statement of Patient/Guarantor Financial Position

Instructions

Please call your Customer Service Representative at 785-623-5100 to discuss your financial position. This information will help us to assess your financial situation and determine what assistance may be available for you. Note that until your financial statement has been reviewed and approved, you will be financially responsible for your medical bill(s).

Along with this completed form, please supply the following:

- Copies of recent pay stubs (2-3 copies)
- Social Security Benefit Statement (if applicable)
- Copies of bank checking and saving accounts statements (last month)
- Copy of latest tax return

For questions please call 785-623-5100 or 1-800-260-7090

Please return to HaysMed, Attn: Customer Service, 2220 Canterbury, Hays, KS 67601, by _____

PATIENT INFORMATION	ACCOUNT NUMBER(S)
Name _____	_____
Address _____	_____
City/State/Zip _____	_____
SS# _____	_____
Date of birth _____	_____
Employer _____	_____
Employer address _____	_____
Number of dependents _____	_____
Ages of dependents _____	_____

(Spouse)

GUARANTOR INFORMATION <small>(If other than patient)</small>	RESPONSIBLE PARTY INFORMATION <small>(If other than patient)</small>
Name _____	Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
SS# _____	SS# _____
Date of birth _____	Date of birth _____
Employer _____	Employer _____
Employer address _____	Employer address _____
Number of dependents _____	Number of dependents _____
Ages of dependents _____	Ages of dependents _____

Financial Assistance Application, Cont.

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ASSETS			MONTHLY EXPENSES		
Vehicle Model/Year _____	\$	Value	Rent/Mortgage	\$	_____
Vehicle Model/Year _____	\$		Gas/Electric/Water	\$	_____
Bank Name _____		Balance	Telephone	\$	_____
Address _____	\$		Child Support	\$	_____
Bank Name _____		Balance	Child Care	\$	_____
Address _____	\$		Food/Groceries	\$	_____
Real Estate		Market Value	Medications	\$	_____
_____	\$		Auto (Gas/Repairs)	\$	_____
_____	\$		Insurance	\$	_____
Other Assets	Description	Value	Life and/or Disability	\$	_____
_____		\$	Health	\$	_____
(i.e., boat, camper, livestock, etc.)		\$	Auto	\$	_____
_____		\$	Homeowner's	\$	_____
			School Expenses	\$	_____
MONTHLY INCOME				Balance	Lendor/Creditor
Patient's Earnings	Gross Income	\$ _____ A	Auto Loan	\$ _____	Monthly Payment
	Minus FICA & Income Tax	-\$ _____ B	Home Loan	\$ _____	\$ _____
	Net Income	\$ _____ C	Other Loan(s)	\$ _____	\$ _____
Responsible Party/	Gross Income	\$ _____ D		\$ _____	\$ _____
Spouse's Earnings	Minus FICA & Income Tax	-\$ _____ E	Medical Bills	\$ _____	\$ _____
	Net Income	\$ _____ F		\$ _____	\$ _____
Child Support/Alimony Received		\$ _____ G	Credit Cards	\$ _____	\$ _____
Interest/Dividends		\$ _____ H		\$ _____	\$ _____
Rents/Royalties		\$ _____ I		\$ _____	\$ _____
Social Security		\$ _____ J		\$ _____	\$ _____
Pension/Annuity/Disability		\$ _____ K		\$ _____	\$ _____
Other (list) _____		\$ _____ L			
TOTAL MONTHLY NET INCOME		\$ _____	Total Monthly Expenses	\$ _____	
(Add C+F+G+H+I+J+K+L)					

CERTIFICATION:

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by HaysMed. I hereby grant permission to HaysMed and representative(s) to investigate the information contained herein, and to obtain a credit report when applicable.

Patient's Signature

Date

Responsible Party's Signature (if other than patient)

Date