NEWMAN
REGIONAL HEALTH

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Return Completed application with proof of income, etc to:

Newman Regional Health
Attn: Credit & Collections Coord
1201 W. 12th Ave
Emporia, KS 66801

Patient's Full Name _____ Service Requested _____

Patient's Date of Birth _____ *Patient's SSN _____

Guarantor's Full Name _____ Spouse _____ Phone _____

Present Street Address _____ City _____ State _____ Zip _____

Previous Address if above is less than two years _____

Employer _____ Spouse Employer _____

Number of Household Members _____ Ages of Household Members _____

Name of nearest relative not living with you _____

Address _____ Relationship _____ Phone _____

LIST BELOW, THE TOTAL FAMILY ANNUAL INCOME OF ALL THE MEMBERS OVER 18 YEARS OF AGE:

Wages		Alimony	
Farm or Self Employ		Child Support	
Public Assistance		Pensions	
Social Security		Dividends, Interest, Rent	
Unemployment Comp		Other	
TOTAL INCOME			

***LIST BELOW, THE TOTAL FAMILY ASSETS:** $ _____

Checking Account		Real Estate Owned	
Savings Account		Automobile Owned	
Certificate of Deposit		Stocks, Bonds & Securities	
Farm Equip/Livestock		Other:	

LIST BELOW, YOUR TOTAL OBLIGATIONS: $ _____

Rent		Credit Card Payment	
House Payment		Finance Companies	
Car Payment		Make & Model of Cars	
Other			

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I GIVE PERMISSION TO VERIFY THE ABOVE INFORMATION.

Signature _____ Date _____

Approved: _____Date _____ Denied: _____Date _____

Comments: _____

_____

* Items not required for emergency room and primary care visits

NEWMAN REGIONAL HEALTH
UNCOMPENSATED & MEDICAL INDIGENT HEALTH CARE
PROGRAM

STATEMENT OF PURPOSE

To provide financial assistance for healthcare to patients who cannot afford to pay and who are not covered by health insurance, or who are not eligible for benefits from the Jones Foundation or other charitable funds.

GUIDELINES − VERIFICATION OF INCOME AND ASSESTS

Patient eligibility for uncompensated health care is determined by measuring family income against the Income Poverty Guidelines established by the Community Services Administration. To verify annual income, the applicant will be required to provide the following:

1. Current Pay Stubs
2. Copy of your most current income tax return, including all schedules.
3. Any applicable forms approving or denying unemployment compensation or Workers' Compensation.
4. Written verification of wages from employer if pay stubs are not available.
5. Written verification of public welfare agencies.

2024 POVERTY GUIDELINES

Size of Family	Annual Family Income
1	$15, 060
2	20, 440
3	25, 820
4	31, 200
5	36, 580
6	41, 960
7	47, 340
8	52, 720

- For family units with more than 8 members, add $5, 380 for each additional member.
- Students, regardless of their residence, who are supported by their parents or other related by birth, marriage, or adoption are considered to be residing with those who support them.
- Applications must be completed within 90 days of service. Determination of eligibility will be made within thirty working days and the applicant will receive written notice of acceptance or denial.
- Applications may be obtained from the Credit/Collections Coordinator or the Supervisor in the Patient Accounts Department Monday through Friday from 8:00 a.m. to 4:30 p.m.

MEDICAL INDIGENT GUIDELINES

For medical bills that are more than 50% of applicant's household gross income. Applicant must provide proof of all outstanding medical expenses.