# Financial Assistance Application
# Kansas Surgery & Recovery Center

Is this application for future or past services? ☐ Future Services ☐ Past Dates of Service
Where were/are services being performed? _____ Acct#_____

**Patient's Information:**

Last Name First Name Middle Initial Social Security Number Date of Birth

Street Address City State Zip

Mailing Address City State Zip

Please check appropriate box: ☐Single ☐Married ☐Common Law ☐Separated ☐Divorced ☐Widowed

Gender: ☐Male ☐Female Language: ☐English ☐Spanish ☐Other

Home Phone Number _____ Work Phone Number _____

**Person Responsible for Paying the Bill:**

Last Name First Name Middle Initial Relationship to Patient Social Security Number

Name of Insurance Company (VA, Medicare, Commercial, AFLAC, etc.) Effective Date

**Please indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return:** (Use additional sheet of paper if needed)

| NAME | RELATIONSHIP TO PATIENT | DATE OF BIRTH | SOCIAL SECURITY NUMBER | TAX DEPENDENT(Y/N) |
|---|---|---|---|---|
| 1. | Self | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

Are services related to a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No

Is anyone in your household: (Check all that apply)

☐ Pregnant Who? _____
☐ A victim of a crime that caused injury Who? _____
☐ Disabled Who? _____
☐ Not a U.S. citizen Who? _____
If LPR how many years? _____ Immigration status: _____
☐ Eligible for COBRA insurance Who? _____

Do you have or plan to file a personal injury claim ☐ Yes ☐ No to compensate for injuries received?

**Do you receive subsidized Housing, Food Stamps or Women's Infants and Children's Program** ( WIC) ☐Yes ☐No

**Monthly Household Income Information:**

| | Patient | Spouse/Co-Applicant |
|---|---|---|
| Gross Income (before deductions) | | |
| Self Employment Income | | |
| Unemployment | | |
| Social Security/SSI (please specify): | | |
| Retirement (Pension, Annuity) | | |
| Alimony or Child Support | | |
| Interest and Dividends from Investment Accounts | | |
| Real Estate Rental Income | | |
| Other Income | | |
| **Total Income** | | |

**Total Household Income**

**Monthly Household Expense Information:**

| | Total | | Total |
|---|---|---|---|
| Mortgage/Rent | | Groceries | |
| Electricity | | Car Payment (s) | |
| Household Gas | | Day Care | |
| Water/Sewer | | Child Support/Alimony | |
| Phone/Cell Phone | | Student Loans | |
| Cable/Internet | | Medical Expenses | |

**Total Household Expense**

**If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.**

INFORMATION OBTAINED FROM: _____ RELATIONSHIP TO PATIENT: _____

I am applying for financial assistance with Via Christi Health, Inc. (Via Christi) as billing/collection agent for the affiliated healthcare providers indicated above. I understand that it is the expectation of Via Christi that patients use all of their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this Application and supporting documents are true and complete. By signing this form, I agree to allow Via Christi to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to Via Christi for this same purpose. I understand that Via Christi may require more specific proof of any information on this FAA and supporting documents will be provide upon request. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. Via Christi reserves the right to re-evaluate and/or reverse any charitable service designation if material information is not disclosed, or information was misrepresented or deliberately withheld , or if I (or my heirs) make demand for or file a civil action against a third party for personal injuries or damages (including medical charges/expenses). I understand and agree that any financial assistance granted by Via Christi may not be used by me or my legal representatives in any negotiations, settlements or lawsuit for the purpose of enhancing an award of monetary damages. Should this occur, I agree that Via Christi has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that any hospital that rendered medical services to the patient named above may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

_____ _____

Applicant's Signature Date Co-Applicant's Signature Date

**Financial assistance is available Monday through Friday 9:00am to 4:00pm. Call 316-634-0090 and ask for financial assistance.**