



# Pratt Regional Medical Center Financial Assistance Application Form

200 Commodore St. | Pratt, KS 67124 | 620.672.7451 | [prmc.org](http://prmc.org)

### Screening Information

1. Do you need an interpreter?     Yes     No. *If yes, list preferred language:*
2. Has the patient applied for Medicaid?     Yes     No. *You may be required to apply before being considered for financial assistance.*
3. Does the patient receive state public services such as Basic Food or WIC?     Yes     No
4. Is the patient currently homeless?     Yes     No

**Please Note:**

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and ask for additional information or proof of income.
- We will notify you if you qualify for assistance within 14 calendar days of receiving your completed application and documentation.

### Patient and Applicant Information

<b>Patient First Name:</b>	<b>Patient Middle Name:</b>	<b>Patient Last Name:</b>
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	<b>Birthdate:</b>	<b>Social Security # (optional):</b>
<b>Mailing Address:</b> _____ _____ _____		<b>Main Contact Number (s):</b> _____ _____
<b>City:</b>	<b>State:</b>	<b>Email Address:</b> _____
<b>Zip Code:</b>		
<b>Employment status of the person responsible for paying the bill:</b>		
<input type="checkbox"/> Employed (date of hire: _____) <input type="checkbox"/> Unemployed (how long unemployed: _____)		
<input type="checkbox"/> Self-Employed <input type="checkbox"/> Student <input type="checkbox"/> Disabled <input type="checkbox"/> Retired <input type="checkbox"/> Other _____		



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### **Family Information**

List family members in your household, including you. "Family" includes people related by birth, marriage, or adoption who live together.

**FAMILY SIZE:** \_\_\_\_\_

Name:	Date of Birth:	Relationship to Pt:	If 18yrs or older: Total gross monthly income (before taxes):

### **Income Information**

**REMEMBER:** You must include proof of income with your application

**Income verification is required to determine financial assistance. All family members 18 years old or older must disclose their income. You may submit a written signed statement describing your income if you cannot provide documentation. Please provide proof for every identified source of income. Examples include:**

- A "W-2" withholding statement; or
- Last year's income tax return, including schedules if applicable; or
- Social Security Income letter; or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for unemployment compensation.

### **Patient Agreement**

I understand that Pratt Regional Medical Center may verify the information provided and obtain information from other sources to determine eligibility for financial assistance. I affirm that the above information is accurate and correct to the best of my knowledge. I understand if the financial information I give is determined to be false, the result may be a denial of financial assistance, and I may be responsible for and expected to pay for the services provided.

Signature of Person Applying: \_\_\_\_\_ Date: \_\_\_\_\_