Royal Oaks HOSPITAL

FINANCIAL ASSISTANCE ELIGIBILITY APPLICATION

In order for us to assist you financially, it is important that you provide us with the following information regarding your income and assets. This questionnaire is designed to assess your needs and remains confidential. If you have any questions with this form, please contact our Patient Accounts office at (660) 647-9921, ext 215

PATIENT NAME:_____ DATE:_____

RESPONSIBLE PARTY:_____ SSN/ACCT#:_____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. What is the total number of members in your family? _____.

	Name	Relationship	Date of Birth	Social Security #
Patient				
Spouse				
Other				
Child				
Child				
Child				
Child				

2 . Is anyone in the family currently employed or has been employed in the last 12 months? Yes____ No_____

	Current Employers	Gross (mo, bi/mo, wk, bi/wk)	Net (mo, bi/mo, wk, bi/wk)	Dates of Employment
Patient				
Spouse				
Other				

If employed, please verify income by sending copies of your last four (4) paycheck stubs or obtain a signed statement from your employer regarding earnings. If you are self-employed, please verify business income and expenses from last 6 months.

3. Have you ever applied for social security? Yes___ No___. If yes, date when?_____

   What was the outcome? _____

4. Does any family member receive any other income listed below?

Type of Income	Circle One	Monthly Amount
Social Security	Yes or No	$_____
Veteran's Benefits	Yes or No	$_____
Supplemental Social Security	Yes or No	$_____
Railroad Benefits	Yes or No	$_____
Self-employment Income	Yes or No	$_____
Retirement/Pension Benefits	Yes or No	$_____
Child Support or Alimony	Yes or No	$_____
Unemployment Compensation	Yes or No	$_____
Income from Rent	Yes or No	$_____
Income from Dividends, Interest Royalties	Yes or No	$_____
Public Assistance Payments	Yes or No	$_____
Military Family Allotments	Yes or No	$_____
Income from Estates and Trusts	Yes or No	$_____
Regular Insurance or Annuity Payments	Yes or No	$_____
Support from Relatives or Friends	Yes or No	$_____
Crops or other Farm Income	Yes or No	$_____
Worker's Compensation	Yes or No	$_____

5. If you have no source or income, who is supporting you? _____.

How do you pay your bills? _____.

6. Does any household family member have any assets listed below:

ASSETS:	CIRCLE ONE:	VALUE:
Cash	Yes or No	$_____
Credit Cards available balance	Yes or No	$_____
Source of Available Credit	Yes or No	$_____
Savings Accounts	Yes or No	$_____
Checking Accounts	Yes or No	$_____
Life Insurance	Yes or No	$_____
Stocks or Bonds	Yes or No	$_____
Equity in Real Estate	Yes or No	$_____
Savings Certificate	Yes or No	$_____
Trust Fund	Yes or No	$_____
Retirement Accounts	Yes or No	$_____
Money held by another person Or Nursing home	Yes or No	$_____

7. Does any household family member have one or more vehicles, motorcycle or recreational vehicles? Yes or No, if yes please list below.

Name or Owner	Year & Model	Amount Owed	Re-sale Value

8. Are you currently paying for any health insurance coverage? Yes___ No___

If yes, $_____per month, Begin Date:_____ Company:_____

9. When was the last time you had health insurance? _____ Why did it end:_____

10. Do you feel you are disabled, unable to work for the next 12 months? Yes___ No___.

If Yes, explain why:

_____

_____

11. Are you currently unemployed, but seeking employment? Yes___ No___ Date unemployment began:_____

COMMENTS: (PLEASE PROVIDE ANY ADDITIONAL INFORMATION OR COMMENTS REGARDING YOUR FINANCIAL SITUATION).

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_____

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_____

_____

I understand that my case record is confidential and no information will be released from it unless properly authorized by me.

I, certify that I have or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any on information regarding any situation, I am subject to possible prosecution for fraud. By signing this application, I am authorizing the release of any information needed to determine my eligibility, not to exclude address verification, a credit check through national credit bureau, an asset check through the County Tax Assessor, and verification of all benefits listed.

_____ _____

Patient Signature Date

_____ _____

Signature of Responsible/Authorized Person/Title or Relationship Date

_____ _____

Address of Responsible Person or Authorized Person Date

_____ _____

Witness Signature Date

_____ _____

Hospital Representative Signature Date