ROYAL OAKS HOSPITAL

REQUIRED DOCUMENTATION TO SUPPORT
FINANCIAL ASSISTANCE ELIGIBILITY APPLICATION

Date: _____

Dear Patient and/or Responsible Party;

In order for Royal Oaks Hospital to complete your Financial Assistance Eligibility Application, we need for you to send the following documents to us at:

ATTN: Melissa Smith
Royal Oaks Hospital Billing
1800 Community Drive
Clinton, MO 64735

If you have any questions please call Melissa Smith at 660-890-8197.

We have listed below the following items that we need returned to us. We will suspend billing for the next 30 days to give you the opportunity to submit these items to us. If we do not receive the completed and signed financial application and appropriate documentation within 30 days, you will begin receiving statements from us and will be expected to pay your outstanding balance.

You must include the following documents for us to process your application:
(X) Completed "INCOME AND ADDRESS CERTIFICATION" (attached).
(X) Completed "FINANCIAL ASSISTANCE ELIGIBILITY APPLICATION"(attached).
(X) Current W-2 and tax forms for the prior calendar year.
(X) Last 4 paycheck stubs from employer.

Please also include the following documents, if applicable, to assist in processing your application:
( ) Social Security award letter for current year.
( ) Unemployment Compensation Benefit letter.
( ) Copy of Checking Account Statement (prior 3 months).
( ) Alien Registration Card or Valid Passport.
( ) VA Benefit Verification Statement.
( ) Savings Certificate Statement.
( ) Stock or Bonds Statement.
( ) Trust Fund Statement.

Sincerely,

Melissa Smith
Royal Oaks Hospital Billing Department

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INCOME AND ADDRESS CERTIFICATION

I, _____, residing in _____ County, _____ at _____ certify that my family income for the past 12 months has been $_____ and there are _____ people in my family.

Please check how earnings are calculated: ____ hourly ____ weekly ____ monthly

The total family income for the four (4) weeks prior to admission is $_____. The number of weeks that I have worked during the past twelve (12) months is _____. The income information can be verified by calling the following employer(s):

Employer Name	Address	Telephone #

Employer Name	Address	Telephone #

I hereby certify that the above information is true. Royal Oaks Hospital is authorized to contact employers, creditors, disability or welfare sources to confirm the above information. This also includes the rights of examination of my credit bureau file. It is the responsibility of Royal Oaks Hospital to regard this information as confidential.

_____ _____

Guarantor Date Witness Date

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FINANCIAL ASSISTANCE ELIGIBILITY APPLICATION

In order for us to assist out 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.

Patient Name:_____ Date:_____

Responsibly Party Name:_____ SSN/Account#:_____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. What is the total number of members in your family? _____ Please list all members of your family below.

	Name:	Relationship:	Date Of Birth:	SSN#
Patient:		Self		
Spouse:				
Other:				
Other:				
Other:				
Other:				
Other:				

2. Is anyone in the family currently employed or has been employed in the last 12 months? Y/N___

	Current Employers	Gross Income	Net Income	Dates Employed
Patient:				
Spouse:				
Other:				
Other:				

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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, Interests/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	Yes or No	$_____
Support from Relatives/Friends	Yes or No	$_____
Crops or Other Farm Income	Yes or No	$_____
Worker's Compensation	Yes or No	$_____

5. If you have no source of income, who is supporting you?_____
   How do you pay your bills?_____
   _____
   _____

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

Assets	Circle One	Value
Cash	Yes or No	$_____
Credit Card Available Balance(s)	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 *Nursing home or Guardian	Yes or No	$_____

7. Does any household member have one or more vehicles, motorcycles or recreational vehicles?
Yes_____ 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? 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, please explain why:
_____
_____
_____
_____
_____

11. Are you currently unemployed, but seeking employment? Yes_____ No_____
Date Unemployment Began_____

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Comments: Please provide any additional information regarding your financial situation.

_____

_____

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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 of 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 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

_____ _____

Witness Signature Date

_____ _____

Hospital Representative Signature Date