FINANCIAL ASSISTANCE APPLICATION

Osawatomie State Hospital

Ph#: 913-755-7000 Patient Accounts Department

Requesting (check one): ☐Reduction in Balance ☐Eliminate Balance

Section 1

Patient's Full Name: _____ SSN#: _____

Patient's Address (street, city, state): Home Ph#: _____

_____ Mobile Ph#: _____

_____ Other Ph#: _____

Name of Employer: _____ Work Ph#: _____

Address of Employer (street, city, state): _____ Occupation: _____

Length of Employment: _____ Gross Wages: $_____ (before taxes & other deductions)

Patient Marital Status: ☐Single ☐Married ☐ Divorced ☐Separated ☐Widow If Married, Spouse SSN#: _____

Spouse Full Name: _____ Phone#: _____

Name of Spouse Employer: _____ Work Ph#: _____

Address of Employer (street, city, state): _____ Occupation: _____

Length of Employment: _____ Gross Wages: $_____ (before taxes & other deductions)

Full Name of Person Responsible for the Bill: _____ SSN#: _____

Address of Person Responsible for the Bill (street, city, state) Home Ph#: _____

_____ Mobile Ph#: _____

Address of Employer (street, city, state): _____ Occupation: _____

Length of Employment: _____ Gross Wages: $_____ (before taxes & other deductions)

Marital Status: ☐Single ☐Married ☐ Divorced ☐Separated ☐Widow If Married, Spouse SSN#: _____

Full Name Spouse of Person Responsible for the Bill: _____ Phone#: _____

Name of Spouse Employer: _____ Work Ph#: _____

Address of Employer (street, city, state): _____ Occupation: _____

Length of Employment: _____ Gross Wages: $_____ (before taxes & other deductions)

Section 2

Dependents of Responsible Party (as indicated on most recent tax return):

Name	Relationship	Age

Section 3

Gross Family Income Per Month

$_____ Responsible Person's Salary
$_____ Spouse or Parent's Salary
$_____ Social Security Benefits
$_____ Disability Benefits
$_____ Welfare Assistance
$_____ Alimony or Child Support
$_____ Pension
$_____ Interest Income
$_____ Other (describe)
_____

$_____ TOTAL MONTHLY INCOME

Monthly Expenses

$_____ Housing
$_____ Utilities
$_____ Insurance
$_____ Auto Payments
$_____ Charge Accounts
$_____ Monthly Medical
$_____ Food
$_____ Other (describe)
_____

$_____ TOTAL EXPENSES

Section 4

Name of Responsible Person's Bank & Address (city, state):
_____

Checking Account Balance: $_____ Savings Account Balance $_____

Assets: ☐Stocks/Bonds/Certificates of Deposit Value: $_____

☐Property (describe): _____ Value: $_____ Mortgage Amount Owed: $_____

☐Other assets (describe – autos, life insurance, etc): _____ Value: $_____

_____ Value: $_____

Section 5

Describe your special situations affecting your financial status: _____

_____

_____

_____

Section 6

The following documentation MUST accompany this application for assistance. Additional information may be required, particularly when there has been a significant change in your income from one year to another.

1. Prior Year Federal Income Tax Return Form (signed copy)
2. Current Year Federal Income Tax Return Form (signed copy)
3. Prior Year W-2 Forms
4. Current Year W-2 Forms
5. Payroll Check Stubs for the past 3 months
6. Bank Statements for the past 3 months
7. Copies of Social Security or Welfare Benefit Award Letters

If your application is for a reduction in your obligation, please indicate your Proposed Reduction Amount:

$_____

By my signature below, I certify that the above information is an accurate and complete statement of my current financial position and give my permission to verify this information.

Signature of Responsible Party: _____ Print Name: _____ Date: _____

Please return this application and all supporting documentation to:

Osawatomie State Hospital

500 State Hospital Drive

Osawatomie, KS 66064-1813