STATE OF KANSAS, DBA OSAWATOMIE STATE HOSPITAL/AGN: 494
ABILITY TO PAY INFORMATION FORM

***PATIENT**

Name: _____ **ID:** _____ Adm. Date: _____ SSN: _____

Address: _____ County: _____ Phone #:( ) -

Date of Birth: _____ Marital Status: _____

Employer: _____ Address: _____

***RESPONSIBLE PARTY:**

Name: _____ SSN: _____ Relationship: _____

Address: _____ Phone #:( ) -

Employer: _____

Address: _____ Phone #:( ) -

Name: _____ SSN: _____ Relationship: _____

Employer: _____

Address: _____ Phone #:( ) -

***MEDICAL SOURCES OF PAYMENT**

Private Insurance Company _____ Policy No. _____

Policy Holder _____ SSN: _____ Premium Amount _____

Address _____ No. of Covered Dependent _____

Employer: _____

Insurance Company Address: _____

Billing Address: _____

Medicare A (which): _____

Medicare B (which): _____

Medicaid (No.): _____

Champus (ID No.): _____ Date of Eligibility: _____

Policy Holder: _____ Active Duty or Retired: _____

Note: This form must be completed and returned within 20 days to the institution or the full cost of treatment will be charged. This form, or a similar form which obtains the following information shall be used for each admission.

STATE OF KANSAS, DBA OSAWATOMIE STATE
ABILITY TO PAY WORKSHEET_1

Patient ID: **Name:** Adm. Date:
Responsible Party: **Assess. Date:**

TYPE OF INCOME TO BE CONSIDERED IN DETERMINING MONTHLY OBLIGATIONS

A. Income that Must be Reported according to I.R.S. from the previous year

1. Wages, including salaries, bonuses, commissions, fees, and tips $ _____
2. Dividends $ _____
3. Interest $ _____
4. Unemployment compensation (Insurance) $ _____
5. Distribution from Retirement Plan/Pensions, or Annuities $ _____
6. Alimony, seperate maintenance or support payments received from and deductible by spouse or former spouse $ _____
7. Profits from farming, businesses and professions before depreciation $ _____
8. Lump-sum distributions $ _____
9. Gains from the sale or exchange of your personal residence or real estate $ _____
10. Rents and royalties $ _____
11. Share of estate or trust income, including accumulation distributions from trusts $ _____
12. Prizes and awards (contests, raffles, lottery and gambling winnings) $ _____
13. Other income $ _____

TOTAL REPORTED INCOME $ _____

B. Income that is not Reported according to I.R.S. from the previous year

1. All Federal social security benefits, including V.I., disability retirement payments (and other benefits) paid by the veterans Administration, Railroad retirement $ _____
2. Welfare benefits, including SSI $ _____
3. Workmen's compensation benefits, insurance damages, etc., for injury or sickness $ _____
4. Gifts, money, or other inherited property $ _____
5. Life insurance proceeds received because of a person's death $ _____

TOTAL UNREPORTED INCOME $ _____

STATE OF KANSAS, DBA OSAWATOMIE STATE
ABILITY TO PAY WORKSHEET_2

Patient ID: **Name:** Adm. Date:
Responsible Party: **Assess. Date:**

POVERTY INCOME GUIDELINES

The current Poverty Income Guidelines issued by the Department of Health and Human Services and Published in the Federal Register shall be used in determining the monthly obligation. MHRS shall inform the institutions of these guidelines on a fiscal year basis.

Exemptions ____ Poverty Income Guidelines _____

ADJUSTMENT

Insurance Premium $ _____

Number of Covered Dependents ____

Special Sources of Payment ADD: $ _____ LESS: ($ _____)

DETERMINATION OF CHARGEABLE ASSETS

A. Exclusions
Determination of Chargeable Assets shall exclude the following:

1. Residence
2. One Personal Car used for income earning purposes by each of the responsible parties
3. Personal clothing and furniture

B. Assets Inventory: Patient, Spouse, Parent

The Inventory of assets shall reflect current market value less current liabilities against them.

Type of Asset	Current Mkt. Value	Current Liability	Net Value
1. Cash on hand including checking accounts			$ _____
2. Savings Account			$ _____
3. Certificates of deposit			$ _____
4. IRA Accounts			$ _____
5. Money Market Certificates			$ _____
6. Notes Receivable			$ _____
7. Stocks			$ _____
8. Bonds			$ _____

(continued)

Patient ID: **Name:** Adm. Date:
Responsible Party: **Assess. Date:**

B. Assets Inventory (continued)

Type of Asset	Current Mkt. Value	Current Liability	Net Value
9. Mutual fund			$
10. Trusts			$
11. Mortgages and loans Receivable			$
12. Equity in Limited Partnership	$	$	$
*13. Farm Land	$	$	$
*14. Real Estate Excluding Farm Land	$	$	$
15. Pleasure Vehicles and Craft	$	$	$
16. Cash value of Life Insurance	$	$	$
17. Other _____	$	$	$
18. TOTAL NET ASSETS			$
19. Less: An amount per patient and each dependent equal to Maximum asset allowed for Medicaid eligibility			($)
20. TOTAL CHARGEABLE ASSETS			$

COMMENTS

** The County Appraiser/State Department of Property Valuation should be consulted for current valuation*

STATE OF KANSAS, DBA OSAWATOMIE STATE HOSPITAL/AGN: 494
ABILITY TO PAY DETERMINATION FORM

Patient ID: **Name:** Adm. Date:
Responsible Party: **Assess. Date:**

Determination of monthly obligation based on: INCOME, POVERTY INCOME GUIDELINES CHARGEABLE ASSETS, SPECIAL SOURCES OF PAYMENT

A. GROSS INCOME:
1. Reported $ _____

2. Not Reported $ _____

B. LESS POVERTY INCOME GUIDELINES..... ($ _____)

C. ASSESSABLE INCOME.....$ _____

D. % ASSESSMENT RATE..... _____ %

E. MONTHLY OBLIGATION..... $ _____

F. LESS INSURANCE PREMIUM (PRORATED).....($ _____)

G. REVISED MONTHLY OBLIGATION.....$ _____

H. CHARGEABLE ASSETS..... $ _____

I. % ASSESSMENT RATE..... _____ %

J. MONTHLY OBLIGATION.....$ _____

K. SPECIAL SOURCES OF PAYMENT
Add:.....$ _____

Less:.....($ _____)

L. TOTAL MONTHLY OBLIGATION $ _____

You have a right to request an appeal if you disagree with the amount we have determined as your ability to pay within 30 days from the date of this notice.

I/we hereby certify that I/we have been informed of my/our obligation based on the financial information that I/we provided. Further, I/we hereby acknowledge and agree that should I/we fail to honor and pay the reduced amount, then the Department of Social and Rehabilitation Services shall have the right to pursue the full original amount of the maximum basic rate in accordance with K.A.R. 30-26-3 and supported by K.S.A. 59-2006.

Responsible Party(ies) Date

_____ _____

_____ _____

Prepared By: _____ (Patient Accounts Manager)