



*RUSSELL REGIONAL HOSPITAL*

200 South Main St. • Russell, KS 67665-2997 • (785) 483-3131

West Central Kansas Association, Inc. d/b/a

## **Russell Regional Hospital and Russell Regional Hospital Physicians Clinic Financial Assistance Program**

Dear Patient/Guarantor,

Thank you for choosing Russell Regional Hospital and Russell Regional Hospital Physicians Clinic for your healthcare needs. You will find a summary of Russell Regional Hospital and Russell Regional Hospital Physicians Clinic's Financial Assistance Policy and the Financial Assistance Application.

Financial Assistance is available for qualified patients/guarantors to assist in partially, or fully covering medical services provided by Russell Regional Hospital and Russell Regional Hospital Physicians Clinic.

Be sure to complete **ALL** fields on the Financial Assistance Application. If a section does not apply to you, please do not leave the section blank, but instead write N/A. **Incomplete Financial Assistance Applications will not be accepted and will be returned to the applicant to complete.**

**Completed Financial Assistance Applications, along with ALL required supporting documents, are to be turned in to the Business Office at Russell Regional Hospital, 200 S. Main St., Russell, KS 67665.**

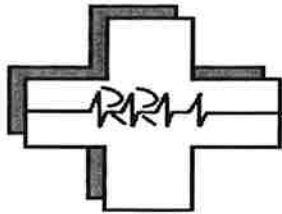
A checklist of required documentation to ensure you obtain and turn in all necessary and required documents is located on the last page of the Financial Assistance Application.

If you need assistance completing the application, please contact the Business Office at 785-483-3131. A financial counselor will be able to assist you in completing the application and will also be able to answer any questions you have about the Financial Assistance Policy.

You will be notified, by letter, if your Financial Assistance Application was approved and the amount that will be provided. You will also be notified, by letter, if your Financial Assistance Application was denied.

Sincerely,

Cindy Jury  
Financial Counselor  
Russell Regional Hospital



*RUSSELL REGIONAL HOSPITAL*

200 South Main St. • Russell, KS 67665-2997 • (785) 483-3131

West Central Kansas Association, Inc. d/b/a

## Financial Assistance Policy Summary

The Russell Regional Hospital and Russell Regional Hospital Physicians Clinic's Financial Assistance Program exists to provide eligible patients partially or fully discounted emergent or medically-necessary care.

A summary of the Financial Assistance Program can be found online as well. Please visit <https://www.russellhospital.org/> to view the Financial Assistance Program Summary.

Patients seeking Financial Assistance must apply for the program, which is summarized below.

**Eligible Services** – Emergent and/or medically necessary healthcare services provided by Russell Regional Hospital and/or Russell Regional Hospital Physicians Clinic.

**Eligible Patients** – The Financial Assistance Policy applies to all patients regardless of sex, age, race, religion, national origin, or sexual orientation. Patients receiving eligible services can apply for financial assistance.

### How to Apply

Financial Assistance Application may be obtained/completed/submitted as follows:

- Obtain an application at Russell Regional Hospital and/or Russell Regional Hospital Physicians Clinic's front desks or by requesting one from the financial counselor at Russell Regional Hospital.
- Request to have an application mailed to you by calling 785-483-3131 and speaking to the Business Office at Russell Regional Hospital or 785-483-3333 and speaking to the receptionists at Russell Regional Hospital Physicians Clinic.
- Request to have an application emailed to you. Contact the Russell Regional Hospital Business Office at 785-483-3131 or Russell Regional Hospital Physicians Clinic at 785-483-3333.
- Obtain an application by visiting <https://www.russellhospital.org/>.

### Determination of Financial Assistance Eligibility

Patients are eligible for financial assistance based on their total household income. Patients with no insurance, will not be charged more for emergency or other medically necessary care than those who have insurance. Patients who do not have insurance, but appears they may qualify for Medicaid, must apply for coverage and receive a written denial from Medicaid prior to having their financial assistance application processed.

A copy of Russell Regional Hospital and Russell Regional Hospital Physicians Clinic's Financial Assistance Policy can be requested by calling the Business Office at 785-483-3131, by requesting one in writing at the address stated above, or by visiting <https://www.russellhospital.org/>.

Please contact the Russell Regional Hospital Business Office at 785-483-3131, with any questions.

# Russell Regional Hospital Russell Regional Hospital Physicians Clinic Financial Assistance Application

A complete financial assistance application (including ALL required documentation) must be received at Russell Regional Hospital Business Office **within 240 days from the date of your first statement** to be eligible.

## Applicant Information

Include ALL members of the household: yourself, spouse, significant other, dependents, etc.

	Name	Relationship	Date of Birth
Responsible Party (Self)		SELF	
Spouse or Significant Other			
Dependent 1			
Dependent 2			
Dependent 3			
Dependent 4			
Other adults in household			

**\*If you have more than 4 Dependents, please write their name, relationship and date of birth on a separate piece of paper.\***

Applicant Social Security Number: \_\_\_\_\_

Spouse Social Security Number: \_\_\_\_\_

Street Address	City	State	Zip Code

Mailing Address (if different from above)	Telephone Number(s):
	Home: _____ Work: _____ Cell or Other: _____

## Income

Does anyone in your household have any of the following resources? Circle Yes or No for each item. Complete ALL columns in the chart below. If Yes is circled, please provide the required documentation.

Source of Income	Circle Yes or No	Amount	How often is income received?	Provide Required Documentation
TANF – Temporary Assistance for Needy Families	YES NO			Supporting Documentation
Food Stamps	YES NO			Supporting Documentation
Self-Employment	YES NO			Current Federal Income Tax Return with ALL Schedules
Unemployment	YES NO			Supporting Documentation
Worker's Compensation	YES NO			Supporting Documentation
Social Security Income (SSI)	YES NO			Supporting Documentation
Railroad Retirement	YES NO			Supporting Documentation
Child Support - Alimony	YES NO			Printout from KPC
Disability Insurance Payments	YES NO			Supporting Documentation
Other Pension or Compensation	YES NO			Supporting Documentation
Money from other persons or gifts	YES NO			Letter from person money was received
Military Dependency Allotment/Allowance	YES NO			Supporting Documentation
Estates/Trusts	YES NO			Supporting Documentation
Rental Income	YES NO			Supporting Documentation
Royalty Income	YES NO			Last 3 months check stubs
Commissions or lump sum payments	YES NO			Supporting Documentation
Other (Explain)	YES NO			Supporting Documentation

If you or your spouse/significant other are working, fill out the chart below.  
**CURRENT EMPLOYMENT OF SELF, SPOUSE/SIGNIFICANT OTHER AND OTHER INCOME (if applicable)**

	Employer	Pay Frequency Weekly, Bi-Weekly, Semi-Monthly or Monthly	Hourly Wage	Hours worked per week
Self – Primary Job				
Self – Secondary Job				
Spouse/Significant Other Primary Job				
Spouse/Significant Other Secondary Job				
Other adult in household – Primary Job				
Other adult in household – Secondary Job				

	Circle Yes or No	Amount	Bank Name	Name(s) of Person(s) on Accounts	Required Documentation
Checking Account	YES NO				3 most recent full bank statements
Savings Account	YES NO				3 most recent full bank statements
Conservatorship/Trust	YES NO				Supporting Documentation
Other	YES NO				Supporting Documentation

### Expenses

	Lenders	Market Value	Balance	Monthly Payment
Home – Own/Rent				
Automobile				
Automobile				
Utilities				
Other Expenses				

Credit Cards/Charge Accounts	Last 4 of Account #	Balance	Payment

### Assets

	Bank	Bank Address	Last 4 of Account #	Balance
Checking				
Savings				

**Assets continued**

**Real Estate**

	Address	Value

**Other Assets/Investments**


**Health Insurance**

Policy	Circle One	Comments
Do you or anyone listed on the application have health insurance?	YES   NO	If Yes, provide copies of health insurance card(s). Please indicate who the subscriber is and the subscriber's date of birth.
Do you or anyone listed on the application have Medicaid or KanCare?	YES   NO	If Yes, provide copies of each family member's cards with Medicaid or KanCare.
If No, have you applied for Medicaid? Were you approved? If Yes, do you have a spenddown? What is your spenddown amount?	YES   NO YES   NO YES   NO \$ _____	<b>If you have applied for Medicaid, provide a copy of the Notice of Decision.</b> <b>If you have a spenddown, please provide a copy of the letter with your spenddown amount.</b>

Applications for Medicaid or KanCare can be found online at <https://www.kancare.ks.gov>

Insurance Name: \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Names of covered family members: \_\_\_\_\_

Insurance Name: \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

Names of covered family members: \_\_\_\_\_

\*If more room is needed, please attach a separate piece of paper with required information.\*

**\*\*Provide copies of ALL CURRENT Insurance Cards\*\***

# Certification Statement

I understand that I assume full responsibility for the accuracy of the statements and information provided on this application. I understand Russell Regional Hospital will use these statements to determine my eligibility for the Financial Assistance Program. If any information changes that I reported on this application, it is my responsibility to contact Russell Regional Hospital to report the changes. I also understand any false statements, documents or concealment of fact may result in the immediate termination of any Financial Assistance granted to me or anyone I have listed on this application.

I CERTIFY THAT THE STATEMENTS MADE ON THIS APPLICATION ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. Each adult listed on this application must sign.

\_\_\_\_\_  
Signature of Applicant or legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Spouse/Significant Other (if applicable)

\_\_\_\_\_  
Date

## Financial Assistance Check List

- \_\_\_ Complete copy of your most recent Federal Income Tax Return and all schedules (Self Employed)
- \_\_\_ Last year's W-2 forms (If paystubs are not available).
- \_\_\_ Copies of the three (3) most recent, consecutive paystubs or a statement from your employer.
- \_\_\_ Complete copies of three (3) most recent bank statements (savings, checking, etc.)  
INCLUDE ALL PAGES OF YOUR BANK STATEMENTS.
- \_\_\_ Copies of unemployment or disability compensation benefits statements (if applicable)
- \_\_\_ Copies of pension benefits stubs (if applicable)
- \_\_\_ Copies of Social Security Income (if applicable)
- \_\_\_ Copy of Food Stamp allocation (if applicable)
- \_\_\_ Copy of government assistance notices (if applicable)
- \_\_\_ Copy of Medicaid approval or denial letter
- \_\_\_ Copies of CURRENT insurance cards for ALL people in the household
- \_\_\_ Business tax returns (if applicable)

**Financial Assistance Applications turned in without required documentation will not be processed. You will be sent a letter stating your application will not be processed until ALL documentation is received.**