HAYSMED

Financial Assistance Application

Statement of Patient/Guarantor Financial Position

PAWNEE VALLEY COMMUNITY HOSPITAL
A HAYSMED PARTNER

Instructions

Please call your Customer Service Representative at (785) 623-5100 to discuss your financial position. This information will help us to assess your financial situation and determine what assistance may be available for you. Note that until your financial statement has been reviewed and approved, you will be financially responsible for your medical bill(s).

Along with this completed form, please supply the following:

- **Copies of recent pay stubs (2-3 copies)**
- **Social Security Benefit Statement (if applicable)**
- **Copies of bank checking and saving accounts statements (last month)**
- **Copy of latest tax return**

For questions please call (785) 623-5100 or 1-800-260-7090
Please return to HaysMed, Attn: Customer Service, P.O. Box 8110, Hays, KS 67601, by _____

PATIENT INFORMATION	ACCOUNT NUMBER(S)
Name _____	_____
Address _____	_____
City/State/Zip _____	_____
SS# _____	_____
Date of birth _____	_____
Employer _____	_____
Employer address _____	_____
Number of dependents _____	_____
Ages of dependents _____	_____

(Spouse)

GUARANTOR INFORMATION (If other than patient)	RESPONSIBLE PARTY INFORMATION (If other than patient)
Name _____	Name _____
Address _____	Address _____
City/State/Zip _____	City/State/Zip _____
SS# _____	SS# _____
Date of birth _____	Date of birth _____
Employer _____	Employer _____
Employer address _____	Employer address _____
Number of dependents _____	Number of dependents _____
Ages of dependents _____	Ages of dependents _____

Financial Assistance Application, Cont.

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ASSETS

Value

Vehicle Model/Year _____ $_____

Vehicle Model/Year _____ $_____

Bank Name _____

Balance

Address _____ $_____

Bank Name _____

Balance

Address _____ $_____

Real Estate — Market Value

_____ $_____

_____ $_____

Other Assets — Description — Value

_____ $_____

(i.e., boat, camper, livestock, etc.)

_____ $_____

MONTHLY INCOME

Patient's Earnings	Gross Income	$_____	A
	Minus FICA & Income Tax	- $_____	B
	Net Income	$_____	C
Responsible Party/	Gross Income	$_____	D
Spouse's Earnings	*Minus FICA & Income* Tax	- $_____	E
	Net Income	$_____	F
Child Support/Alimony Received		$_____	G
Interest/Dividends		$_____	H
Rents/Royalties		$_____	I
Social Security		$_____	J
Pension/Annuity/Disability		$_____	K
Other (list)_____		$_____	L
TOTAL MONTHLY NET INCOME		**$_____**	
(Add C+F+G+H+I+J+K+L)			

MONTHLY EXPENSES

Rent/Mortgage	$_____
Gas/Electric/Water	$_____
Telephone	$_____
Child Support	$_____
Child Care	$_____
Food/Groceries	$_____
Medications	$_____
Auto (Gas/Repairs)	$_____
Insurance	$_____
Life and/or Disability	$_____
Health	$_____
Auto	$_____
Homeowner's	$_____
School Expenses	$_____

	Balance	Lendor/Creditor	Monthly Payment
Auto Loan	$_____	_____	$_____
Home Loan	$_____	_____	$_____
Other Loan(s)	$_____	_____	$_____
	$_____	_____	$_____
	$_____	_____	$_____
Medical Bills	$_____	_____	$_____
	$_____	_____	$_____
	$_____	_____	$_____
Credit Cards	$_____	_____	$_____
	$_____	_____	$_____
	$_____	_____	$_____

Total Monthly Expenses $ _____

CERTIFICATION:

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services provided by HaysMed. I hereby grant permission to HaysMed and representative(s) to investigate the information contained herein, and to obtain a credit report when applicable.

_____ _____

Patient's Signature — Date

_____ _____

Responsible Party's Signature (if other than patient) — Date