

## Financial Assistance Application

### PART A – Patient information

Last name \_\_\_\_\_ First name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Marital status:  Single  Live-in partner  Married  Separated  Divorced  Widowed

Do any of your dependents have any NKC Health accounts that need to be considered within this application?

Yes  No

### PART B – Documents

Please attach copies of the following documents:

- Most recent income tax return
- Bank statements for the last two months
- Pay stubs for the last two months or Social Security/Disability Benefit letter

If unable to provide such documentation, please contact a Resource Counselor (816) 691-2598 to discuss other evidence that may be provided to demonstrate eligibility.

### PART C – Responsible party information

Examples include: spouse, live-in partner, parent, guardian, guarantor, etc. **If same as patient, skip Part B.**

Last name \_\_\_\_\_ First name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

SSN \_\_\_\_\_ Home phone \_\_\_\_\_ Cell phone \_\_\_\_\_ Work phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### PART D – Dependents

List all dependents who reside in the applicant's home **for whom the applicant takes financial responsibility.**

Check the appropriate relationship box for each dependent. **Attach an additional sheet if necessary.**

NAME	AGE	SPOUSE/PARTNER	PARENT	CHILD (UNDER 21)	OTHER

Number of people in household: \_\_\_\_\_ Number of children under age 21 in the home: \_\_\_\_\_ OVER >

## PART E – Household income & assets

### Monthly gross (last 30 days)

Source of income	Patient/applicant	Spouse/live-in partner	Asset type	Patient/applicant	Spouse/live-in partner
Gross wages/salary	\$	\$	If owned, value of house	\$	\$
Social Security benefit	\$	\$	Loan balance	\$	\$
Disability benefit	\$	\$	Other property, value	\$	\$
Unemployment benefit	\$	\$	Loan balance	\$	\$
State assistance	\$	\$	Stocks/bonds	\$	\$
Alimony/child support	\$	\$	Certificate of Deposit (CD)	\$	\$
Rental/business Income	\$	\$	IRAs/Retirement fund	\$	\$
Student loans/grants	\$	\$	Checking/savings account(s)	\$	\$
Other	\$	\$	Investment account(s)	\$	\$
<b>Total income</b>	<b>\$</b>	<b>\$</b>	<b>Total assets</b>	<b>\$</b>	<b>\$</b>

If income is \$0, please check all that apply:

- Lives with relative(s)
  Lives with friend(s)
  Retired
  Unemployed
  Disabled
  Homeless
  Student

Other \_\_\_\_\_

## PART G – Signature

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

Signature of patient/responsible party \_\_\_\_\_

Date \_\_\_\_\_



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