

# Financial Assistance Application Checklist

Use this checklist as you complete your application to ensure you have all the necessary items. For more detailed instructions, refer to the packet called “How to Complete the Financial Assistance Application”.

**IF YOU DO NOT HAVE HEALTH INSURANCE**, you must work with ElevatePFS before completing this application. ElevatePFS works with North Kansas City Hospital to help patients obtain health insurance and understand financial care options. To contact ElevatePFS, call **(888) 689-6960**.

Complete **Part A – Patient Information**

Complete **Part B – Documents**

**Attach copies of all the following documents. If you are married, you must also attach each document for your spouse, even if they do not need financial assistance.**



1. Most recent income tax return filed with the IRS

You                       Spouse (if they filed their taxes separately)

**Helpful Tip:** An income tax return is labeled with **Form 1040** at the top.

2. **All** bank statements for the last 2 months

You                       Spouse

**Helpful Tip:** Please include all pages of your bank statements, even if they are blank.

3. **All** pay stubs for the last 2 months **OR** Social Security/Disability Benefit Letter

You                       Spouse

**Helpful Tip:** Log in to your Social Security account at <https://secure.ssa.gov/> to download and print a benefit letter. It will have the Social Security Administration’s name and logo at the top. You may also call 1-800-772-1213 (TTY 1-800-325-0778) on Monday – Friday from 8:00 a.m. – 7:00 p.m. to request a copy by mail.

**Please note:** You may be asked to provide additional documentation or explanation at the discretion of the Financial Resource Counselor.

Complete **Part C – Responsible Party Information**

Complete **Part D – Dependents**

Complete **Part E – Household Income & Assets**

Complete **Part F – Signature & Date**

## 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 to Part D.**

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: \_\_\_\_\_

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## 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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