LIBERTY HOSPITAL

2525 Glenn W. Hendren Drive ● Liberty, Missouri 64069-1002 ● 816 781-7200

Dear Patient:

We understand that a hospitalization may result in unplanned expenses. Our Board of Trustees has approved several payment options. These options include payment by check, cash, Discover, MasterCard or Visa. If your circumstances do not allow you to take advantage of these options, we will be glad to consider other payment arrangements. In order for us to work with you, we request that you work with us by providing the information indicated on the financial application. We are not a lending institution and, therefore, do not charge interest on payments that are made. We ask for the same type of information that is requested by a lending institution. It is needed so that we might work together to arrive at a payment amount that is fair for you and the hospital.

Your financial application, complete with attachments, must be **returned to us no later than 240 days** after you received your first post-discharge billing statement, but may be returned sooner. Failure to return your completed application within this time frame will result in denial of the application. Also, you must live in one of the following Counties that comprise our service area: Clay, Caldwell, Carroll, Clinton, Daviess, Grundy, Harrison, Livingston, Platte or Ray.

Information needed for review of financial application:

___ Prior year household income tax return or IRS non-filing letter
___ Most recent two (2) pay stubs of all members contributing to household income
___ Verification and amount of Unemployment, Work Comp benefits and/or disability benefits
___ Current W-2 and 1099 Form
___ List of current stocks/bonds, retirement accounts, mutual funds (i.e. IRA, CDs, 401K)
___ Copies of payments from Social Security, Supplemental Security, Survivor Benefits
___ Current utility bill, rent invoice or mortgage bill for proof of residence
___ Proof of Medicaid denial
___ Current month bank statement(s) **please cross out account numbers
___ Amount of educational assistance, alimony, child support, or veteran's payments
___ Amount of income from interest, dividends, rental property, royalties, estates, or trusts
___ Letter from family/parents/friends verifying support
___ Letter from school verifying full-time student status
___ Documentation of homeless shelter residence

For additional informational about financial assistance, please contact Liberty Hospital's Business Office at 816-792-7110 or Financial Counselor at (816) 407-4861, M-F 8:00 a.m.- 4:30 p.m. Completed applications can be returned in person to Patient Registration/Admitting Office at Liberty Hospital, located at 2525 Glenn Hendren Drive, Liberty, MO, 64068 or mailed to the same address: attention Business Office.

This information obtained will be kept confidential and used only for Financial Assistance determination.

PLEASE RESPOND IN ENGLISH

LIBERTY HOSPITAL
Financial Assistance Application

Patient Account #(s):_____

Responsible Party or Guarantor:_____ Social Security # _____-_____-_____

Patient's Name:_____ Social Security # _____-_____-_____

Patient's Relationship to Applicant: ☐ Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ Child ☐ Other:_____

Address:_____ City_____ County _____

State:_____ Zip Code:_____ Home Phone: (___)_____-_____Cell Phone: (___)_____-_____

*please indicate if this is the current address for: Patient ☐ Correspondence ☐ Guarantor ☐

Have you recently made, or plan to make an application for Medicaid and/or Medical Assistance?: Yes _____ No _____

Date of Application:____/____/_____

Number of family members living in the home (spouse, domestic partners and dependents):_____

EMPLOYMENT INCOME VERIFICATION (List all persons in household who are employed)

Name	Relationship to Patient	Employer's Name & Address	Monthly Income Gross
			$
			$
			$
			$

OTHER INCOME (List monthly accounts)

Source	Name	Relationship to Patient	Monthly Value
Social/Supplemental Security, Survivor Benefits			
Unemployment/Work Comp/Disability Benefits			
Stocks, Bonds, retirement accounts, mutual funds			
Education assistance, alimony, child support, veteran' s benefits			
Interest, dividends, rental property, royalties, estates, trusts			
Other			
Other			

RESOURCES (List all resources owned by members of the household and value)

Bank or Company	Owner	Bank Accounts	Savings	Stocks/ Bonds	CDs	Retirement Accounts	Mutual Funds	Other
		$	$	$	$	$	$	$
		$	$	$	$	$	$	$

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LIBERTY HOSPITAL
Financial Assistance Application

By my signature below, I certify that the information and documentation provided is an accurate and complete statement of my current financial position and give my permission to verify this information. My failure to pay any reduced or adjusted balance will subject me to the normal billing and collection practices of Liberty Hospital.

Signature of Applicant:_____

Date:_____

Documents needed for review of financial application:

___
____ Prior year household income tax return or IRS non-filing letter
___ Most recent two (2) pay stubs of all members contributing to household income
___ Verification and amount of Unemployment, Work Comp benefits and/or disability benefits
___ Current W-2 and 1099 Form
___ List of current stocks/bonds, retirement accounts, mutual funds (i.e. IRA, CDs, 401K)
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**** If you have special circumstances you would like considered, please attach a separate letter with an explanation.***

DO NOT COMPLETE BELOW THIS LINE OFFICE ONLY

FINANCIAL ASSISTANCE

Total Family Gross Income: _____
Family Size: _____
Hospital Financial Assistance Guideline Amount: _____
Amounts Generally Billed: _____

Total Amount Approved: _____

Rejected: _____

Notification letter sent to patient on _____/_____/_____

Approved by: _____ Date: _____Time:_____