FINANCIAL ASSISTANCE PROGRAM PACKET

This packet will be used to determine your eligibility for financial assistance. A copy of AmberMed's Payment Policy is included in the packet for your review.

Please complete the application to the best of your ability. If you have questions or concerns over any area of the application, write "**N/A**" in the space. Please do not leave any blank spaces on the application. We can discuss these areas of concern at a later time.

The application **MUST** be returned within **TWO WEEKS** (14 days) for processing. If you need assistance obtaining the required information please return the application and I can assist you with the other documents i.e. bank statements, paystubs, tax returns, etc.

If you have any questions or concerns regarding the application process or need assistance completing the application contact:

Savannah Allmer, (785) 677-4116 or via email: savannah.allmer@ambermed.com.

Thank you for your cooperation and allowing us to serve your healthcare needs!

FINANCIAL ASSISTANCE PROGRAM

AmberMed offers financial assistance to patients who meet eligibility criteria under the Federal Poverty Level Guidelines.

A copy of the financial assistance policies and application can be obtained by the following sources:

Website:	www.ambermed.com
In-Person:	AmberMed Business Office
Email:	savannah.allmer@ambermed.com
Phone:	(785) 677-4116
Mail:	AmberMed FAP Application PO BOX 167 Hoxie, KS 67740

Financial Assistance Program eligible persons will not be charged more than amounts generally billed for emergency and medically necessary care. Financial assistance will generate a reduction of charges up to 80% of the billed amount for those who qualify.

In accordance with federal law, AmberMed, does not discriminate based on age, gender, ethnicity, or ability to pay. AmberMed will not require patients to pay upfront for emergency services, nor attempt to collect a debt while a person is in an emergency department.

*(*La solicitud para asistencia financier en relicio a sus cuentas medicas con AmberMed esta disponible en Espanol).*

826 18th St. Hoxie, Kansas 67740
P.O. Box 167 Hoxie, Kansas 67740
Phone: (785) 675-3281 Fax: (785) 675-3840
www.ambermed.com

FINANCIAL ASSISTANCE APPLICATION

Patient/ Responsible Party Information		Spouse Information (if applicable)	
Name		**Name**	
Date of Birth		**Date of Birth**	
Social Security Number		**Social Security Number**	
Physical Address		**Physical Address**	
Mailing Address		**Mailing Address**	
Home Phone		**Home Phone**	
Cell Phone		**Cell Phone**	
Employment Status		**Employment Status**	
Employer Name & Phone Number:		Employer Name & Phone Number:	

Household Members/ Dependents:		
Name	**Date of Birth**	**Relationship to Applicant**

Do you have insurance? Yes No Have you provided a copy to the hospital? Yes No

Would you like to discuss insurance options that may be available to your household members? Yes No

*Revised 8/19/2024

Monthly Income: (Attach copies of Proof of Income)			
Income Type:	**Patient/ Responsible Party**	**Spouse**	**Other members of the household (18 and older)**
Wages (Gross)			
Social Security			
Pensions			
Unemployment			
Workman's Compensation			
Government Assistance			
Disability Payments			
Veteran's Payments			
Oil Royalties			
Other Income			
Monthly Subtotal			
TOTAL INCOME	**MONTHLY:**	**YEARLY:**	

Expenses:	**Monthly:**	**Assets:**	**Value:**
Mortgage or Rent		Checking Account	
Utilities (Gas, Electric, Water)		Savings Account	
Phone		Business Account	
Food		Farm Account	
Child Care			
Health Insurance			
Other Insurance (Auto, Life, etc.)			
Hospital/ Physicians			
Other Expenses			
TOTAL EXPENSES:	$	**TOTAL ASSETS:**	$

Other Pertinent Information Regarding Financial Status
I, declare the information provided is true and correct to the best of my knowledge. I authorize AmberMed to verify the information provided to complete my application. I understand I may have to provide additional documentation to determine my household's eligibility under the Financial Assistance Policy. If any information provided is inaccurate, incomplete or falsified I will be responsible for the entire balance and any prior payment arrangements may be void.

Patient/ Responsible Party Signature:	**Date:**
*For Hospital Use: Community Resources Signature:	Date:
Application Determination: Approved Denied	Date:
Reason for Denial:	
CFO Signature:	Date:

*Revised 8/19/2024

FINANCIAL ASSISTANCE APPLICATION CHECKLIST

1. Complete the Financial Assistance Application.
2. Submit Documentation:
   a. 3 months verification of wages (i.e. paystubs, employer statement, W2, 1099)
   b. Most recent 3 months copies of bank statements for ALL accounts (checking/savings)
   c. Copy of the most recent tax return
   d. Verification of other income (i.e. Social Security, VA, unemployment, pensions, etc.)

Did you provide verification of your income for the last (3) months? YES NO

If No, please explain:

Did you provide your most recent (3) months bank statements for all accounts? YES NO

If No, please explain:

Did you provide your most recent tax return? YES NO N/A
- If you are not required to file, please circle "N/A"

If No, please explain:

Applicant Signature:	Date:
Community Resources Signature:	Date: