TMC

TRUMAN MEDICAL CENTERS

Better. For Everyone.

For Office Use Only
Inpt Discount _____
SD Discount _____

Discount Application / Eligibility Statement

HH MR#:_____ LW MR#: _____ Date Applied:_____

Approved: ☐ Yes ☐ No Effective Dates: _____ to _____Back-dated to _____

%FPG:_____ Discount %:_____ Resource Counselor:_____

Applicant Name (First, Middle, Last) Date of Birth (mm/dd/yy)

Address (House No., Street or Rural Route, PO Box) City, State, Zip

Home Phone Number Work Number Alternate Phone Number

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Address (House No., Street or Rural Route, PO Box) City, State, Zip

Home Phone Number | Work Number | Alternate Phone Number

Below, list your name **first**, then list all other persons who live with you.

(First, Middle, Last)	Sex	Relationship (Spouse, Son, Sister, Friend)	Birth Date	Social Security Number	Mark (X) For Applicant

1. Are all of the persons applying residents or U.S. citizens? ☐ Yes ☐ No If No, list the following information for applicants above who are not U.S. citizens: Name, immigration status, registration number and date of entry:

_____

2. I/We are residents of Jackson County or Kansas City Missouri: ☐ Yes ☐ No

3. The reason I/We are applying **(X all that apply):**

___ I have commercial insurance but need assistance
___ I am unemployed
___ I have Medicare and need assistance with coinsurance and deductible
___ I am retired and do not have insurance
___ I am not covered by my employer

Mail application to hospital of service rendered:

Truman Medical Center-Hospital Hill
2301 Holmes
Kansas City, Missouri 64108
Attention: Financial Counseling Center

Truman Medical Center-Lakewood
7900 Lee's Summit Road
Kansas City, Missouri 64139
Attention: Financial Counseling Center

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Employment

1. Are you now employed? ☐ Yes ☐ No
   If yes, name of your employer: _____

Amount paid before deductions: $_____ *Check One* ____Weekly ____Bi-weekly ____Monthly ____2x's Month

2. Is anyone else in your home employed? ☐ Yes ☐ No
   If yes, who? _____
   Name of employer: _____

Amount paid before deductions: $_____ ____Weekly ____Bi-weekly ____Monthly ____2x's Month

3. Does anyone in your home operate their own business or are they otherwise self-employed? ☐ Yes ☐ No
   If yes, list who, describe what type of self-employment (baby-sitting, farm income, other) and amount earned:

_____

_____

4. If you are not employed and have no income, how are you supporting yourself?

_____

_____

Other Income

I/We receive other income from **(X all that apply):**

__ Social Security
__ Supplemental Security Income
__ Trust Funds/Annuities
__ Pensions/Retirement/Disability/VA
__ Interest or Dividends
__ Unemployment Compensation
__ Utility assistance from Houseing Authority
__ Assistance from friends or relatives
__ Financial Aid: Student loans, tuition and fees
__ Food Stamps/TANF
__ Child Support Alimony
__ Cash gifts from family and friends
__ Other (explain below where the money comes from and the amount):

_____

_____

Insurance

I/We have Medicare: ☐ Yes ☐ No If yes, list name(s) _____

I/We have insurance that covers prescriptions: ☐ Yes ☐ No If yes, complete the following:

I/We have other insurance: ☐ Yes ☐ No If yes, complete the following:

Person Insured	Insurance Company	Policy Number	Type of Coverage

Real Property

I/We Own or are Buying Real Estate: ☐ Yes ☐ No

List Kind and Location	Whose Name is on Deed?	Current Value	Amount Owed	How is it Used (Home, Rental, Acreage, Other)?

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I/We have the following cash, securities, or personal property (X all that apply):

Insurance	In Whose Name?	Location	Value
___ Checking Accounts / Joint Checking Accounts Account numbers:			
___ Savings Accounts/ Joint Savings Accounts, Christmas Club Saving, Certificates of Deposit, Credit Union, IRA			
___ Cash on hand (after bills are paid)			
___ Stocks, Bonds, or Other investments, 401K Trust Funds			
___ Notes or mortgages owed to you			
___ Property held in safe deposit box (give location and contents of box)			

Office Use Only:

Family Size: Income: $

I understand the information I have given is subject to verification and authorize Truman Medical Center, Incorporated to obtain my **CREDIT BUREAU FILE** for the purposes of assisting in this verification procedure.

I further understand it is necessary to **RE-APPLY** for discounted services at least **every 180 days** or at any time my financial situation changes. I understand failure to do so may make me ineligible for further discounted services. I understand that discounts are given only after all other payment sources have been exhausted.

I fully understand the information I have provided will be used to determine whether I am eligible for free or discounted care at Truman Medical Center, Incorported, and that if this statement is found to be knowingly falsified, I may be subject to fines or imprisonment or both.

THE FINANCIAL COUNSELING CENTER RESERVES THE RIGHT TO DISCONTINUE OR RETROACTIVELY CANCEL MY DISCOUNT IF ALL INFORMATION IS NOT PROVIDED IN A TIMELY MANNER, OR IF ADDITIONAL INFORMATION IS DISCOVERED WHICH CONTRADICTS THE INFORMATION I HAVE PROVIDED.

The above statement is sworn to and certified by: _____ _____

Signature of Hospital Witness Date

My signature below certifies under penalty that all declarations made in this eligibility statement are true, accurate and complete.

_____ _____

Signature of Applicant Date

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Please read carefully, initial and sign below:

I understand that the Truman Medical Center Discount (TMC Discount) is for my medical services at Truman Medical Centers only and is **not** a health insurance program. I also acknowledge I might be subject to the **Individual Responsibility Requirement** fine from the Internal Revenue Service (IRS) if I do not buy health insurance from my employer, from a private health insurance company or from the Health Insurance Marketplace.

_____Initials

I understand that I must report **any changes** in my circumstances **within ten days of occurrence** by providing verification of those changes. For example: obtaining health Insurance, Medicaid, Crime Victim's assistance, settlements, or changes in income, residency, marital status and household composition among others.

_____Initials

I understand that the information I have given will be used to verify my eligibility to receive reduced or no cost medications. I consent to this information being provided to Manufacturer Patient Assistance Programs, or their representatives, for the purpose of auditing to verify my eligibility to participate in Manufacturer Patient Assistance Programs.

_____Initials

_____ Date:___/___/_____

Signature of Applicant

_____ Date:___/___/_____

Signature of Financial Counselor