TMC TRUMAN MEDICAL CENTERS | university health

Financial Assistance Application / Eligibility Statement

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

Below, list your name first, and then list all the other persons who live with you.						
(First, Middle, Last)	**Sex**	**Relationship (Spouse, Son, Sister, Friend)**	**Birth Date**	**Social Security Number**	**US Citizen? Y/N**	**Mark (X) For Applicant/s**
		SELF				

1. For those above who are not U.S. Citizens, please list the following information: Name, immigration status, registration number and date of entry:

_____

2. I/We are residents of Jackson County or Kansas City, Missouri: ☐ Yes ☐ No
3. Is anyone in the household currently receiving food stamps? ☐ Yes ☐ No
4. Are you currently residing in a homeless shelter or a rehabilitation facility? ☐ Yes ☐ No
5. Was your visit to TMC the result of a crime? ☐ Yes ☐ No If yes, was a police report filed? ☐ Yes ☐ No
6. Were you in foster care when you turned 18 years of age? ☐ Yes ☐ No
7. Is anyone in the household blind or do you suffer from a mental or physical medical condition that prevents you from working? ☐ Yes ☐ No
8. If female, are you pregnant or do you suspect that you may be? ☐ Yes ☐ No

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Insurance

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

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

Person Insured	Insurance Company	Policy Number	Type of Coverage

Household Income

Name of Employer	Who works there?	Frequency of Pay: Weekly, Bi-weekly, Monthly or Twice per Month	Amount Paid (Before Deductions)

1. 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:

_____

Type of Income (check all that apply)	Person Receiving	Amount Per Month
☐ Social Security		
☐ Supplemental Security Income (SSI)		
☐ Unemployment Compensation		
☐ Worker's Compensation		
☐ Trust Fund / Annuity		
☐ Pensions/Retirement/Disability/VA		
☐ Financial Aid/Student Loans/Work Study		
☐ TANF		
☐ Child Support or Alimony		
☐ Interest or Dividends		
☐ Utility Assistance from Housing Authority		
☐ Gifts or assistance from friends or family		
☐ Rental Property Income		
☐ Other: Please list where the money comes from and amount:		

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

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Assets

I/We Own or are Buying Real Estate: ☐ Yes ☐ No If yes, please complete the information below:

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

Vehicles – List cars, trucks, motorcycles, recreational vehicles and others:

Make / Model	Year	Owner	Current Value	Amount Owed

Other Assets:	In Whose Name?	Location	Value
___ Checking Accounts Account numbers:			
___ Savings Accounts, Christmas Club Saving, Credit Union			
___ Cash on hand (after bills are paid)			
___ Stocks, Bonds, or Other investments			
___ Notes or mortgages owed to you			
___ Property held in safe deposit box (give location and contents of box)			
___ Retirement Accounts (401K, 403B, IRA, etc.)			
___ Life Insurance with a cash value			
___ Certificate of Deposit			

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Please Read Carefully and Sign Below:

I understand that if I receive Financial Assistance from Truman Medical Center (TMC), it is for my medical services at TMC 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.

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.

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

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.

I understand it is necessary to **RE-APPLY** for financial assistance at least **annually** 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 financial assistance is given only after all other payment sources have been exhausted.

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

IF FINANCIAL ASSISTANCE IS APPROVED, I UNDERSTAND THAT TMC RESERVES THE RIGHT TO DISCONTINUE OR RETROACTIVELY CANCEL MY FINANCIAL ASSISTANCE IF ADDITIONAL INFORMATION IS DISCOVERED WHICH CONTRADICTS THE INFORMATION I HAVE PROVIDED OR IF MY MEDICAID APPLICATION IS DENIED FOR FAILURE TO COOPERATE.

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

Signature of Applicant (Digital Signature Allowed) _____ Date _____

Signature of Witness (If Applicant signed with an X) _____ Date _____

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Please Return or Mail application to hospital of service rendered:

Truman Medical Center-Health Sciences District
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

Drop boxes are conveniently located just inside the main entrance at the Health Sciences District (formerly Hospital Hill) and in the registration area inside the Bess Truman Medicine Center Entrance at Lakewood.