Financial Assistance ● 2525 Glenn Hendren Drive ● Liberty, Missouri 64068 ● 816 407 4861

LIBERTY HOSPITAL

LIBERTYHOSPITAL.ORG

Liberty Hospital strives to provide assistance to patients and families who are unable to fulfill their financial obligations to us for medical services. We offer a Financial Assistance Program, interest free loans, and long-term payment plan options. For "No Interest Payment Plans" and "Uninsured Discounts" it is NOT necessary to fill out this application. You may call our Extended Business Office at (816) 792-7110 to talk to a representative.

Financial Assistance Options Include (Application Required):

- Partial Financial Assistance: 70% - 95% discount of patient portion due. Some services may be excluded.
- Full Financial Assistance: 100% discount of patient portion due. Some services may be excluded.

Financial Assistance Options Include (No Application Required):

- Prompt Pay Discount of 15% paid within 30 days of receiving first statement
- No Interest Payment Plans available in house to patients 0-12 months
- Extended months No Interest Payment Plans outsourced through Commerce and Clear Balance

Financial Assistance Application Overview:

A completed financial assistance application and proof of income must be submitted in order for us to consider a financial need discount and/or full financial assistance. Once we receive your completed application, we may assess whether or not you qualify for the financial assistance program. Those who qualify may receive assistance with their hospital bills for services provided at Liberty Hospital and physician bills for physicians employed only by Liberty Hospital. Financial need discounting and full financial assistance is not available for all services. Consideration for future services will be based on medical necessity and catastrophic costs.

Financial Assistance Application Instructions:

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, DeKalb, Gentry, Grundy, Harrison, Livingston, Mercer, Platte, Ray or Worth.**

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

DOCUMENTS TO OBTAIN ARE LISTED ON THE BACK OF THIS APPLICATION

LIBERTY HOSPITAL FINANCIAL AID APPLICATION

Patient Account #(s):_____

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

Responsible party's name if patient is minor or has DPOA : _____

Patient's Relationship to Applicant: ☐ Self ☐ Spouse/Partner ☐ Parent/Guardian ☐ DPOA

Address: _____ City_____ State _____

Zip Code: _____ County: _____ Phone# to be reached at: _____-_____-_____

Email address: _____

Marital Status: ☐ Single ☐ Live-in Partner ☐ Married ☐ Legally Separated ☐ Divorced ☐ Widowed

Number of family members living in the home including yourself, spouse, domestic partners and dependents that share income: _____.

1. Are you employed?	Yes or No
If no, date you became unemployed?	_____/_____/_____
2. If you have a spouse, is your spouse employed?	Yes or No
If no, date you became unemployed.	_____/_____/_____
3. Do you receive Social Security (SSA)?	Yes or No
If you have a spouse, does your spouse SSA?	Yes or No
4. Do you receive Social Security Disability (SSI)?	Yes or No
If you have a spouse, does your spouse SSI?	Yes or No

If you receive any income, <u>please go to the next page</u>

If you are reporting $0.00 income, please complete the Support Statement explaining how you and/or your family are supporting yourself and attach any documentation that can support your statement.

☐ Lives with relative(s) ☐ Lives with friend(s) ☐ Unemployed ☐ Homeless ☐ Student

SUPPORT STATEMENT

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

Name	Relationship to Patient	Employer name	Monthly Income Gross
			$
			$

OTHER INCOME (List monthly accounts)

		Monthly Value
Social/Supplemental Security benefits	Yes or No	_____
Survivor Benefits	Yes or No	_____
Retirement accounts/pensions	Yes or No	_____
Veteran's benefits	Yes or No	_____
Alimony	Yes or No	_____
Child support	Yes or No	_____
Rental property	Yes or No	_____
Education assistance/grants	Yes or No	_____
Food Stamps	Yes or No	_____
Unemployment Benefits	Yes or No	_____
Other income _____	Yes or No	_____

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

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

In addition to the completed financial assistance application we also need the following documentation:

- Proof of all gross (pretax) income. ***Choose your type of income and collect all documents that are on the following page in the box***

- Proof of Residency. Include a copy of one of the following acceptable documents that displays your address during the time that medical care was received: utility bill, phone or cable bill, a rent receipt, a mortgage statement or your most recent voter registration card.

By my signature below, I certify that I have carefully read this application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge and belief. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Responsible Party Signature: _____
Date Completed: _____

All documents in "Required Documents" are required to complete the application

Type of Income	Required Documents
Employment Income	• Copy of Individual tax return (Form 1040) for current tax year • Copy of two most recent paystubs • Copy of current W2 Form • Copy of bank statement with all credit and debits shown • Proof of residency • Copy of retirement funds (i.e. IRA, CDs, 401K)
Self-Employment	• Copy of Individual tax return (Full tax return with Form 1040 and Schedule Forms) for current tax year • Copy of bank statement with all credit and debits shown • Proof of residency
Social Security/Retirement	• Copy of monthly payment notification from Social Security Administration or Form 1099 from previous year payout • Copy of bank statement with all credit and debits shown • Proof of residency • Copy of retirement funds or pensions received as income
Disability	• Copy of monthly payment notification from Social Security Administration or Form 1099 from previous year payout • Copy of bank statement with all credit and debits shown • Proof of residency
Unemployment	• Copy of Individual tax return (Form 1040) for current tax year • Copy of Award Letter from unemployment stating weekly or monthly benefit amount • Last paystub from employer • Copy of bank statement with all credit and debits shown • Proof of residency
No income	• Copy of Individual tax return (Form 1040) for current tax year – if not filed in years then an IRS non filing letter • Document verifying how patient is supporting themselves • Copy of bank statement with all credit and debits shown if applicable • Proof of residency

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