GUIDELINES

Patients will be ineligible for financial assistance if the applicant has not followed through with a payment plan on a previous financial assistance determination, or if a legal suit has been filed against the applicant on accounts included in the application.

Financial Assistance will not be considered for accounts totaling less than $100.00.

A patient may not apply for financial assistance more than one time in a 12 month period.

We ask patients to establish a payment plan with Kimball Health Services to ensure the account is not sent to collections during the application process. Participation in a payment plan for account balances is not required for application consideration. However we do request patients establish a payment plan with Kimball Health Services to ensure the account is not sent to collections during the application process.

Please address all sections of the application. If there is a section that is not applicable, please write **"none"** in that section.

If you have any questions please call the Social Services Designee at 308-235-1961.

COMMUNITY ASSISTANCE

Have you applied for any of the following?

	Date Applied	Status
Medicaid	________________	________________
County Assistance Fund	________________	________________
State Economic Assistance	________________	________________
Every Woman Matters	________________	________________
Veterans Services	________________	________________
Social Security Administrations	________________	________________

REQUIRED DOCUMENTATION

In order for Kimball Health Services to consider your application of assistance, we require as many of the following documents that are application to your situation.

- □ Photo ID driver's license, state issued identification or military identification.
- □ **For minor's,** a copy of school enrollment if no photo ID is available.
- □ Copy of Medicare or Medicaid card, if applicable.
- □ Social Security card.
- □ Verification of income and assets (including custodial/noncustodial parents).
- □ Most recent tax return.
- □ Copies of two months of your most recent pay stubs from each employment (8 stubs if paid weekly, 4 stubs if paid bi-weekly).
- □ Social Security Award letter for the current year, **if applicable**.
- □ Unemployment compensation benefit letter, **if applicable.**
- □ Verification of alimony or child support, **if applicable.**
- □ Two months of the most current bank statements for all accounts.
- □ **If self-employed**, business balance sheet and income statement, including list of assets
- □ If legally separated provided documentation of legal separation or divorce decree.
- □ Copy of all Kimball Health Services bills you are requesting assistance for.
  Applicant requesting assistance for □ Hospital accounts □ Clinic accounts

APPLICANT/GUARANTOR

Why are you requesting assistance? ____

____

Applicant Name: ________________________ Social Security number: ________

Address: ____

Phone number: ___________________________ Date of Birth: __________________

Occupation: _________________________ Supervisor: ___________________

Employer: __________________________ Phone number: ______________

Address: ____

Gross Salary $ ______________________ □ Weekly □ Bi-Weekly □ Monthly

Marital Status □ Single □ Married □ Legally Separated □ Divorced

If legally separated or divorced attach that documentation and move to the next application section

If applicant is a minor under the age of 19 or has a guardian the following section is required.

Spouse/Guarantor Name: ___________________ Social Security number__________________

Address (if different from applicant): ____

Phone number: ___________________________ Date of Birth: ____________________

Occupation: _________________________ Supervisor: ___________________

Employer: __________________________ Phone number: ______________

Address: ____

Gross Salary $ ______________________ □ Weekly □ Bi-Weekly □ Monthly

HOUSEHOLD

Please List All Persons Living in Your Home (including yourself):

	First and Last Name	Date of Birth	Relationship
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

ASSETS

Bank Accounts:

	Owner	Institution	Acct. Number	Balance
1.				
2.				
3.				
4.				

Other Income: (Alimony, Child Support, Social Security for Dependents, Pension/Retirement, Interest, Dividends, Royalties, Rental Income)

	Payee	Source	Acct. Number	Monthly Amount
1.				
2.				
3.				

Other Assets: (Stocks, Bonds, CD's, Credit Union, IRA, 401K, Keogh Accounts, IRA's, Annuities, etc)

	Payee	Source	Acct. Number	Monthly Amount
1.				
2.				
3.				

PRIMARY RESIDENCE

Do you: □ Rent □ Own □ Mortgage □ Friends/family

Landlord/Mortgage Lender:

Landlord/Mortgage Lender Address:

Monthly payment: Utilities expense $ ________________

Tax assess value of Real Estate $ Estimated Equity $ ________________

ADDITIONAL REAL ESTATE

	Address	Assessed Value	Own/Morgtage	Estimated Equity
1.				
2.				
3.				

AUTOMOBILES/OTHER VEHICLES

	Year/Make/Model	Current Value	Balance Owed
1.			
2.			
3.			
4.			
5.			

BANKRUPTCY

Have you ever filed Bankruptcy? ________ Yes ________ No

If yes, please state type and date ____

Are accounts listed in this application included in filing? ________ Yes ________ No

AUTHORIZATION AND AGREEMENT

I hereby submit the above information for the purpose of allowing Kimball Health Services to evaluate my financial status to determine my eligibility for various financial assistance programs. I do hereby authorize Kimball Health Services to verify this information which may include a credit bureau report, employment and/or income verification, and appropriate supporting documents.

I attest that the above information and all income documentation provided are complete and accurate as shown. I realize that should any of this information prove to be false, all discounts awarded will be reversed, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

By applying for Financial Assistance, I also agree to establish and honor a payment plan for the outstanding balances for which assistance is being requested. Following the determination of assistance it will be the patient's responsibility to contact Kimball Health Services to make any adjustments to their payment plan. Failure to maintain a current payment plan, may result in KHS adjusting the charges back onto the account and sending the account to our collection agency.

NOTIFICATION OF CHARITY DETERMINATIONS

- The Application date will be the date upon which a completed application and all supporting documentation is received by Kimball Health Services. The application date will be documented at the top of the completed application for future reference.
- The hospital will notify the applicant, in writing, of its final determination within 60 business days of the application date.
- If an application is denied, written notice will include a reason for the denial and the date of determination.
- Any appeal of the determination is to be submitted, by the patient, in writing within 15 business days to the Chief Financial Officer.
- The Chief Financial Officer, or designee will notify patients' in writing within 15 business days of the appeal date and will include the reason for upholding or changing the denial and the date of the appeal decision.

Unsigned applications will not be processed.

______________________________ _______________
Patient/Guarantor Signature Date

______________________________ _______________
Spouse Signature Date

APPLICATION FOR FINANCIAL ASSISTANCE
(this page for administrative use)

Applicant Name: _________________ Social Security Number: ________________

Applicant Address: ____

Applicant requesting assistance for ☐ Hospital accounts ☐ Clinic accounts ☐ Both

Date initial documents received by KHS: ____________________________________

Date of written request for additional documents by KHS: ________________________

Application Date (date all documents are received by KHS): _______________________

Date of determination: __________________________ ☐ Application incomplete

Date of notice mailed to patient: ____

Last date available for appeal: ____

Date application filed: ____________ Employee Signature_____________________

Reviewed 12/2023