Financial Assistance Application
Via Christi Health Inc.

Is this application for future or past services? ☐ Future Services ☐ Past Dates of Service
Where were/are services being performed? _____ Acct#_____

Patient's Information:

Last Name First Name Middle Initial Social Security Number Date of Birth

Street Address City State Zip

Mailing Address City State Zip

Please check appropriate box: ☐Single ☐Married ☐Common Law ☐Separated ☐Divorced ☐Widowed

Gender: ☐Male ☐Female Language: ☐English ☐Spanish ☐Other

Home Phone Number _____ Work Phone Number _____

Person Responsible for Paying the Bill:

Last Name First Name Middle Initial Relationship to Patient Social Security Number

Name of Insurance Company (VA, Medicare, Commercial, AFLAC, etc.) Effective Date

Please indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return: (Use additional sheet of paper if needed)

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TAX DEPENDENT(Y/N)
1.	Self			
2.				
3.				
4.				
5.				
6.				
7.				

Are services related to a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No

Is anyone in your household: (Check all that apply)

☐ Pregnant Who? _____
☐ A victim of a crime that caused injury Who? _____
☐ Disabled Who? _____
☐ Not a U.S. citizen Who? _____
If LPR how many years? _____ Immigration status: _____
☐ Eligible for COBRA insurance Who? _____

Do you have or plan to file a personal injury claim ☐ Yes ☐ No to compensate for injuries received?

MONTHLY HOUSEHOLD INCOME INFORMATION	PERSON 1	PERSON 2	PERSON 3
Name of household member			
Name of employer			
Hours per week worked			
Monthly income from:			
Wages per hour	$		
Self-Employment	$		
Investment Accounts	$		
Real Estate Rentals	$		
Unemployment (since ____/____/____)	$		
Retirement (Pension, Annuity)	$		
Social Security	$		
SSI	$		
Alimony/Child Support	$		
Public Assistance/Food Stamps	$		
Other Income	$		
Does anyone in the household have any of the following: (Check all that apply)			
☐ Checking Account Balances	$		
☐ Health Savings Account	$		
☐ Savings Balance	$		
☐ CD Account Balances	$		
☐ Bonds Value	$		
☐ IRAs, 403B, 401K Balance Specify:	$		
☐ Other Savings & Investments Balance Specify:	$		

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

INFORMATION OBTAINED FROM: _____ RELATIONSHIP TO PATIENT: _____

I am applying for financial assistance with Via Christi Health, Inc. (Via Christi) as billing/collection agent for the affiliated healthcare providers indicated above. I understand that it is the expectation of Via Christi that patients use all of their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this Application and supporting documents are true and complete. By signing this form, I agree to allow Via Christi to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to Via Christi for this same purpose. I understand that Via Christi may require more specific proof of any information on this FAA and supporting documents will be provide upon request. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. Via Christi reserves the right to re-evaluate and/or reverse any charitable service designation if material information is not disclosed, or information was misrepresented or deliberately withheld , or if I (or my heirs) make demand for or file a civil action against a third party for personal injuries or damages (including medical charges/expenses). I understand and agree that any financial assistance granted by Via Christi may not be used by me or my legal representatives in any negotiations, settlements or lawsuit for the purpose of enhancing an award of monetary damages. Should this occur, I agree that Via Christi has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that any hospital that rendered medical services to the patient named above may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

_____ _____

Applicant's Signature Date Co-Applicant's Signature Date

Financial counselors are available Monday through Friday 9:00am to 4:00pm. For assistance please call the number associated to the location where services were performed.

Wichita services 316-268-5178, option 2 Pittsburg services 620-232-0198, option 2 Wamego services 785-458-7000, option 2 Manhattan services 785-565-4794, option 2

Via Christi Health, Inc

Name:_____ Date of Birth:_____

Social Security Number:_____

1. I authorize the following to use, disclose, receive and exchange my case record information with Via Christi Health, Inc owned or managed healthcare providers: KDHE Division of Health Care and Finance, Kansas Department of Children and Families, Maximus, Disability Determination Services, Crime Victims Compensation Board, Kansas Legal Services, Social Security representative/attorney, or my Disability Advocate.

2. I authorize my case record information, including any protected health information contained therein, to be used, disclosed, received and exchanged for the following purpose(s). Check all that apply:
   - ☐ Application for financial assistance/benefits;
   - ☐ At the request of the individual;
   - ☐ To assist me in applying for medical benefits to pay for my medical expenses;
   - ☐ Other:(specify) _____.

3. **I authorize_____ to be my representative for purposes of application, maintenance, and management of my medical assistance. Said representative shall be authorized to receive any/and all communications from KDHE or Kansas Department of Children and Families.**

4. I understand that I have the right to revoke this authorization at any time by notifying Via Christi Hospitals Wichita, Inc., or one of the others named herein making the disclosure, in writing, but if I do, it will not have any effect on disclosures or uses made by Via Christi Hospitals Wichita, Inc. before it received my revocation.

5. I understand that I may inspect or copy the protected health information, if any, to be used or disclosed under this authorization. I understand I may refuse to sign the authorization. I understand that the refusal to sign this authorization may mean that the use and/or disclosure described in this form will not be allowed.

6. I understand that once the uses and disclosures of protected health information have been made pursuant to this release that the released information may be subject to re-disclosure by any recipient and will no longer be protected by federal privacy laws.

7. I understand that any releasing agency named herein will not condition treatment or payment on my providing authorization for this use or disclosure except to the extent the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party.

8. I understand that this authorization will expire on ___/___/___ (DD/MM/YY) or on the occurrence of the following event:_____.

9. A photocopy of this authorization shall be as valid as the original.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

If signed by Legal Representative, Relationship to Patient Signature of Witness