Kansas Surgery & Recovery Center

Summary of Financial Assistance Policy

Kansas Surgery & Recovery Center (KSRC) has a commitment to and respect for each person's dignity with a special concern for those who struggle with barriers to access healthcare services. Kansas Surgery & Recovery Center has an equal commitment to manage its healthcare resources as a service to the entire community. In furtherance of these principles, Kansas Surgery & Recovery Center provides financial assistance for certain individuals who receive emergency or other medically necessary care from Kansas Surgery & Recovery Center. This Summary provides a brief overview of Kansas Surgery & Recovery Center's Financial Assistance Policy.

Who Is Eligible?

You may be able to get financial assistance. Financial assistance is generally determined by your total household income as compared to the Federal Poverty Level. If your income is less than or equal to 250% of the Federal Poverty Level, you will receive a 100% charity write-off on the portion of the charges for which you are responsible. If your income is above 250% if the Federal Poverty Level but does not exceed 400% of the Federal Poverty Level, you may receive discounted rates on a sliding scale. Patients who are eligible for Financial assistance will not be charged more for eligible care than the amounts generally billed to patients with insurance coverage.

What Services are covered?

The Financial Assistance Policy applies to emergency and other medically necessary care. These terms are defined in the Financial Assistance Policy. Elective services are not covered by the Financial Assistance Policy.

How Can I Apply?

To apply for financial assistance, you typically will complete a written application and provide supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Policy application.

How Can I Get Help with an Application?

For help with a Financial Assistance Policy and Financial Assistance Policy application, you may contact KSRC's Business office located at 2770 N Webb Road, Wichita, KS 67226 or by calling 1-316-634-0090.

How Can I Get More Information?

Copies of the Financial Assistance Policy and Financial Assistance Policy application form are available at ksrc.org and at the following location: 2770 North Webb Road Wichita, KS 67226.

Free copies of the Financial Assistance Policy and Financial Assistance Policy application also can be obtained by mail by calling KSRC's Business office at 1-316-634-0090.

What If I Am Not Eligible?

If you do not qualify for financial assistance under the Financial Assistance Policy, you may qualify for other types of assistance. For more information, please contact KSRC's Business Office at 1-316-634-0090.

Translations of the Financial Assistance Policy, Financial Assistance Policy application, and this plain language summary are available in the following languages upon request:

Spanish

Vietnamese

KANSAS
SURGERY &
RECOVERY
CENTER

Dear Patient/Applicant,

Kansas Surgery and Recovery Center is driven by compassion and dedicated to providing personalized care for all—especially those most in need. It is our mission and privilege to offer financial assistance to our patients. Financial assistance is available only for emergency and other medically necessary care. Thank you for trusting us to care for your healthcare needs.

We are sending this letter and the attached financial assistance application because we received your request. Please complete both sides, including your signature and date before returning it.

Along with the application, please provide a copy of at least one of the following items as your proof of income. If you are married or have lived with a significant other for 6 months or longer, they will also need to provide a copy of at least one of the following items as proof of their income before the application can be processed.

- Copies of 3 most recent paystubs from employer
- Copies of most recent yearly tax return (if self-employed, include all schedules)
- Social Security and/or Pension Retirement Award Letter
- Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age 25
- Other income validation documents
- Copies of bank statements from last 3 months
- Copy of receipt of unemployment benefits

If you receive assistance from or live in a home with a family or friends, please have them complete the attached form labeled "Letter of Support." This will not make them responsible for your medical bills. This will help show how you are able to afford living expenses. If you receive no assistance from family and friends, you do not need to fill out the Letter of Support form.

Finally, please also provide documentation as proof of your outstanding monthly medical and pharmacy/drug costs.

Please know that the completed application along with proof of income must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.

Please print and mail or hand deliver your completed application to the following address:

Mail or hand deliver to:
2770 N. Webb Rd., Wichita, KS 67226

If you have any questions about this application, please call one of our Patient Representatives at 316-630-4209

Sincerely,

Patient Financial Services

Financial assistance application form

KANSAS SURGERY & RECOVERY CENTER

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date_____ Account number _____

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party spouse information

(If patient is same as responsible party, fill in spouse information for patient.)

Name (first and last)_____

Birth date_____ Marital status_____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse information for patient.)

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Number of adults and children living in household _____

Assets

Cash/savings/checking accounts _____

Stocks/bonds/investments/CD(s)_____

Other real estate/secondary residence _____

Boat/RV/motorcycle/recreational vehicle _____

Collector automobiles/non-essential automobiles _____

Any pending or planned personal injury or workers compensation actions ____ yes ____No

Other assets _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____

Applicant spouse income _____

Social security benefits _____

Pension/retirement income _____

Disability income_____

Unemployment compensation _____

Worker's compensation _____

Interest/dividend income _____

Child support received _____

Alimony received _____

Rental property income _____

Food stamps _____

Trust fund distribution received _____

Other income _____

Other income _____

Total gross monthly income $ _____

Monthly living expenses

Mortgage/rent_____

Utilities_____

Phone (landline) _____

Cell phone _____

Groceries/food_____

Cable/internet/satellite tv _____

Car payment _____

Child care _____

Child support/alimony _____

Credit cards _____

Doctor/hospital bills _____

Car/auto insurance _____

Home/property insurance _____

Medical/health insurance _____

Life insurance _____

Other monthly expense _____

Total monthly expenses $ _____

I am applying for financial assistance with Kansas Surgery and Recovery Center, LLC, (KSRC). The information I have provided in this Application and supporting documents are true and complete. By signing this form, I agree to allow KSRC 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 KSRC for this same purpose. I understand that KSRC may require more specific proof of any information on this FAA and supporting documents will be provided 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. KSRC 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 KSRC 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 KSRC has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that KSRC may file and maintain a KSRC lien before or after financial assistance is granted on all potential recovery sources.

Signature of Applicant_____ Date _____

KANSAS
SURGERY &
RECOVERY
CENTER

Letter of support

Patient medical record number/account number _____

Supporter's name _____

Relationship to patient/applicant _____

Supporter's address _____

To Kansas Surgery & Recovery Center:

This letter is to advise that(patient's name)

_____

receives little to no income and I am assisting with his/her living expenses.
He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter _____ Date _____