KINGMAN REGIONAL MEDICAL CENTER

Dear KRMC Patient,

Thank you for choosing Kingman Regional Medical Center (KRMC) for your healthcare needs. If you are experiencing financial hardship and are unable to pay your KRMC medical bills, you may qualify for discounts through our Patient Financial Assistance program (please see KRMC's *Patient Financial Assistance Policy* for a description of our qualifying criteria).

To apply for financial assistance, please complete a *Patient Financial Assistance Program Application* within ten (10) business days from when you are notified of your responsibility to pay your medical bills. Your application must be fully completed and signed before it will be considered. The following documentation is also required:

- **Proof of medical insurance status**— If you do not have insurance, provide proof that you have applied for Medicaid (AHCCCS) and/or coverage through the Affordable Care Act insurance exchange
- **Proof of residency**— Current driver's license or other documents proving residency
- **Proof of relationship to household members**— Birth certificate, baptismal certificate, or adoption papers for minor-age children; marriage license; divorce decree or legal separation documents
- **Photocopy of Social Security card** for every member of your household (***Optional***)
- **Documentation of assets**: Bank and credit union statements for the last three (3) months and statements showing other financial assets, such as stocks, bonds, securities, and time certificates. Include all pages of any financial statement, even if blank
- **Documentation of income for all household members**: Check stubs, employer's statement, or self-employment business records showing gross income over the most recent 12 weeks (pay stubs must be consecutive). Also include award letters or documentation of all other income, which includes Social Security, pension income, child support, disability payments, worker's compensation, inheritance income, grant and education benefits, rental income, etc.
- **Previous year tax return** if you are self-employed.

You can bring your application and required documents to KRMC Patient Financial Services located at the Stockton Hill Medical Plaza, 2202 Stockton Hill Road in Kingman, Arizona. Our friendly customer service representatives can assist you with completing the application and required documentation.

If you prefer to mail your application, please verify that your application form is completed in full, signed, and that all required documentation is included. Our mailing address is:

Kingman Regional Medical Center
Attention: Patient Financial Services Dept.
3269 Stockton Hill Road
Kingman, AZ 86409-3619

Please allow us thirty (30) business days to process your application. We will notify you by mail if you qualify and if so, the amount of assistance we can provide.

If you have questions or need help in applying for assistance, please contact KRMC Patient Financial Services at **(928) 263-3534**.

Sincerely,

KRMC Financial Services Department

Patient Financial Assistance Program Application

Patient First Name	MI	Last Name			
Guarantor's First Name	MI	Last Name	Sex	DOB	Social Security # (Optional)
Address or PO Box	City		State	Zip	Phone
# In Household:	Patient Lives in Household: ☐ Yes ☐ No				
# of Children Under 18 in the Household:	# of Dependent Children Over 18:				
# of Dependent Children Over 18 that are Full time Students:	# of Dependent Children That are Disabled:				

Monthly Income Sources	**Husband**	**Wife**	**Children**	**Total**
Employment				
Social Security				
Industrial Comp				
Unemployment				
Pension/Retirement/Annuities				
ADC, GA, Food Stamps				
Other (rental income, child support, spousal, etc.)				
Total Gross Income				

Employer of Responsible Party:				
Address or PO Box	City	State	Zip	Phone
Position:	Monthly Income $	Start Date:		
Checking: ☐ Yes ☐ No	Total Amount $	Bank Name:		
Savings: ☐ Yes ☐ No	Total Amount $	Bank Name:		

I certify that the information given hereon is complete and accurate to the best of my knowledge. I understand that deliberate falsification can lead to denial of consideration. I hereby authorize the hospital to make any necessary inquiries to verify the information provided and to obtain any additional information required by facility.

Applicant Signature:	**Date:**
Co-Applicant Signature:	**Witness Signature:**

Relationship of Household Members: Birth or baptismal certificate or adoption papers for minor-age children, marriage license, divorce decree or legal separation documentation.
Social Security Cards
Proof Of Residency: Current Driver's License, other documents proving residency.
Assets: Bank and credit union statements for the last three (3) months, stocks, bonds, securities, time certificates.
Income for All Household Members: Checks or check stubs/employer's statement listing gross wages, self-employment business records, income award letters/grant or education benefits letter, other documents showing income.
Income Period _____ to _____
Bank Statements for Last Three (3) Months • Previous Year Tax Return