Amberwell Atchison

800 Ravenhill Dr.
Atchison, KS 66002
913-967-2131

APPLICATION FOR FINANCIAL ASSISTANCE

In order for Amberwell Health to process your application, all sections must be completed. Along with your application, please submit the following documents for all members of your household so we can verify your financial situation:

- Bank statements (last two months)
- Pay stubs (last two months)
- Most recent tax returns

SECTION ONE: APPLICANT INFORMATION

Please complete all of the below information regarding demographics and insurance information

Applicant Name: _____ Date of Birth: ___/___/_____
LAST NAME FIRST NAME MIDDLE NAME

Address: _____ City: _____ State: _____ Zip Code _____

Phone Number: (_____) _____ Email: _____

SECTION TWO: ADDITIONAL HOUSEHOLD MEMBERS INFORMATION

Please provide the below information for all immediate family members who live in your home.

For these purposes "family" includes the applicant, applicant's spouse, and all of their children under 18 (natural or adoptive).

	Additional Family Member Name(s)	Date of Birth	Relationship to Applicant
1.			
2.			
3.			
4.			
5.			
6.			

SECTION THREE: FINANCIAL INFORMATION

Please provide any income that members of your household receive.

Income Source	Current Monthly Gross Income - Applicant	Current Monthly Gross Income - Spouse/Other
Employment Income		
All Other Income Sources		

If there is no household income, please use this space to explain how you are being supported:

SECTION FOUR: INSURANCE INFORMATION

Please provide your health insurance/medical coverage information, if applicable.

Name of Insurer: _____ Subscriber ID Number: _____

Subscriber Name: _____ Group Number: _____

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay my medical expenses. I understand that the information provided may be verified, and I authorize Amberwell Health to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill(s). I grant Amberwell Health permission to contact me using any method provided on this application.

Signature of Applicant: _____ Date: _____