

BCMH Family Care Clinics

Adrian Family Care Clinic High Street Family Care Clinic Nursery Street Family Care Clinic Rich Hill Family Care Clinic

Billing & Financial Services Department

615 W. Nursery PO Box 370 Butler, MO 64730 Phone: 660-200-7312

Fax: (660)200-7021

Bates County Memorial Hospital (BCMH) provides financial assistance for medically necessary services per our policy guidelines in the hospital setting, surgical clinic and outpatient specialty clinics **only to residents of Bates County**. Family Care Clinics, as rural health clinics, have no geographical restrictions.

BCMH uses the current federal poverty guidelines and family size as a basis for determining the eligibility for financial assistance.

- > A \$20.00 Co-pay is due at time of service at these locations: Outpatient Specialty Clinic, FCC Adrian, FCC Nursery Street, FCC High Street, FCC RICH HILL and BCMH Surgical Clinic.
- > A \$50.00 Co-pay is due for Emergency Room visits.

List of Documents needed to process application: (Any documents altered will not be accepted)

- 1.) Payroll check stubs copies of last three months.
 - a. If you do not receive check stubs, please submit the past three months of bank statements.
 - b. If you do not receive check stubs, please submit a written notice signed and dated from your employer with earnings information.
- 2.) Copies of any of the following that apply:
 - a. Social Security Income, disability Income, unemployment income, or other income such as dividends, interest, rental income, child support, etc.
- 3.) Written statement from applicant describing current financial/employment situation *(required).
- **4.)** Last year's tax returns **may be requested for** you to provide at a later date.
- 5.) Bank statements copies of last three months.

We Must Receive All Requested Documents In Order To Complete Your Application.

Once all documentation is received, applications are processed within 30 days. Once your application is processed you will receive a determination letter in the mail. If approved, your assistance will be applied to any current outstanding balances. This approval will be valid for 6 months from the date you signed the application. If you are denied you may reapply at any time.

We will do our very best to apply the financial assistance to your accounts. If you receive a statement or phone call in regards to services that you feel should have been covered, please contact us as soon as possible.

As a courtesy, Alliance Radiology and Electric City Emergency Physicians honor BCMH financial assistance policy. You need to fax or mail them a copy of your approval letter along with their statement.

If you have questions, please contact us at 660-200-7312.

Sincerely,



BATES COUNTY MEMORIAL HOSPITAL AND FAMILY CARE CLINICS FINANCIAL ASSISTANCE APPLICATION

(Office Use Only)								
Renewal	Yes	NO						
Valid	to							
Non Potos County	Posidont ECC Or	alv						

							Non Bates C	County Residen	t FCC Only	
				D OF HOUSE						
_ast Name F	First Name		Middle I.	DOB	Age	Telephone No.		County of Resider	ice	
Street Address		Apt No.	City	State	Zip Code		Marital Status		# of Dependents	
Employer Name		Employer Address	s, City, State & Zip	Code					1	
How long employed? Employer Telephone No.				Position Title			Social Security No (Optional)			
			SP	OUSE/PART	NER					
_ast Name F	First Name		Middle I.	DOB Age Social Security No. (Optional)						
Employer Name		Employer Address	s, City, State, & Zip	Code	•	•				
How long employed?		Employer Telepho	mployer Telephone No.							
			TA	X DEPENDE	NTS					
_ast Name F	First Name		DOB		Age	Relationship to Head of H	ousehold	Social Security No).	
			INCOME	E OFFICE U	SE ONLY					
GROSS INCOME		HOURLY MON		MON	THLY QUARTERLY		ERLY	YEARLY		
Primary Wages										
Secondary Wages or other incom	e									
Social Security Income										
Pension										
Disability										
Rental Income										
Alimony / Child Support										
Jnemployment										
State Assistance										
Other (total household income red	quired)									
TOTAL										
hereby certify that I have	not knowin	gly withheld	any informa	tion containe	d on this ar	plication and that a	II information	n disclosed is	correct to the	
hereby certify that I have not knowingly withheld any information contained on this application and that all information disclosed is correct to the best of my knowledge. I give permission for my information to be verified with the IRS or other resources to approve my application.										
X	mormation t	to be verified	i with the IRS	o or other reso	X	pprove my application	UII.			
Patient / Responsible Party Signature Date Spouse/Partner Signature Date										
Bates County Memorial Hosp	ital Represen	tative	Date				Department		Apr-24	