Bates County Memorial Hospital

BCMH Family Care Clinics

ADRIAN CLINIC
HIGH STREET CLINIC
NURSERY STREET CLINIC
RICH HILL CLINIC

Billing & Financial Services Dept.
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 policy guidelines, in the hospital setting, Surgical Clinic, and Outpatient Specialty Clinics exclusively 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 bank statements for the past three months.
    b. If you do not receive check stubs, please submit a signed and dated statement 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. Bank statements: copies of last three months
5. Proof of approval or denial of Medicaid, if applicable. (Denial must be dated within the last 6 months.)
6. Last year's tax returns may be asked for you to provide at a later date.

All requested documents must be received before your application can be completed.

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

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

As a courtesy, Electric City Emergency Physicians honors BCMH financial assistance. You must send them a copy of your approval letter and their statement by mail or fax.

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

Sincerely,

Patient Accounts Financial Representative
Bates County Memorial Hospital

Bates County Memorial Hospital

BATES COUNTY MEMORIAL HOSPITAL AND FAMILY CARE CLINICS FINANCIAL ASSISTANCE APPLICATION

(Office Use Only)
Renewal _____Yes_____NO
Valid _____to_____
Non Bates County Resident FCC Only_____

HEAD OF HOUSEHOLD

Last Name	First Name	Middle I.	DOB	Age	Telephone No.	County of Residence

Street Address	Apt No.	City	State	Zip Code	Marital Status	# of Dependents

Employer Name	Employer Address, City, State & Zip Code

How long employed?	Employer Telephone No.	Position Title	Social Security No. (Optional)

SPOUSE/PARTNER

Last Name	First Name	Middle I.	DOB	Age	Social Security No. (Optional)

Employer Name	Employer Address, City, State, & Zip Code

How long employed?	Employer Telephone No.	Position Title	

TAX DEPENDENTS

Last Name	First Name	DOB	Age	Relationship to Head of Household	Social Security No.

INCOME-- OFFICE USE ONLY

GROSS INCOME	HOURLY	MONTHLY	QUARTERLY	YEARLY
Primary Wages				
Secondary Wages or other income				
Social Security Income				
Pension				
Disability				
Rental Income				
Alimony / Child Support				
Unemployment				
Other (total household income required)				
TOTAL				

I 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		X	
Patient / Responsible Party Signature	Date	Spouse/Partner Signature	Date

Bates County Memorial Hospital Representative	Date	Department	Apr-24