



**BCMh Family Care Clinics**  
ADRIAN CLINIC  
HIGH STREET CLINIC  
NURSERY STREET CLINIC  
RICH HILL 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. The 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 asked for you to provide at a later date* .
- 5.) Bankstatements- copies of last three months
- 6.) Proof of approval or denial of Medicaid if applicable (**denial must be dated within the last 6 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 Electric City Emergency Physicians honors the BCMh financial assistance. **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**

<b>(Office Use Only)</b>	
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)					
<b>TOTAL</b>					

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.

<b>X</b>		<b>X</b>	
Patient / Responsible Party Signature	Date	Spouse/Partner Signature	Date
Bates County Memorial Hospital Representative	Date	Department	Apr-24