Missys' Boutique - Professional Services of KU
FINANCIAL HARDSHIP APPLICATION

Please Return Completed Application to:
Asst. Director Patient Financial Services
2650 Shawnee Mission Parkway
Westwood, KS 66205
Bus: (913) 945-5603
Fax: (913) 945-5617

Patient Information

Patient Name ____

Responsible Party's name (If Different) ____

Account Number ____

Mailing Address

Street ____

Apartment or suite number ____

City & County City: ________________________ County:________

State ____

Zip Code ____

Telephone Number ____

Living Expenses

Please fill out the requested information to the best of your ability. No supporting documentation is necessary. This information will more accurately help us determine a payment arrangement that is suitable to you. Please convert non-monthly expenses such as homeowners insurance to a monthly rate.

Housing & utility expenses:

Monthly rent or house payment: ______________________________

Monthly average home repairs: ______________________________

Monthly average gas bills: ______________________________

Monthly average electric bills: ______________________________

Monthly average water & sewer bills: ______________________________

Monthly avg. home insurance expense: ______________________________

Monthly average property taxes: ______________________________

Totals: ______________________________

Other recurring expenses: ____

____

____

____

Transportation Ownership Expenses:

Monthly lease or loan automobile payment #1: ____________________

Monthly lease or loan automobile payment #2: ____________________

Transportation Operating Expenses (excl. property taxes):

Monthly average gasoline expense ____________________

Monthly average repair & maintenance expense ____________________

Monthly average public transportation expense ____________________

Monthly average insurance expense ____________________

Total Operating Cost ____________________

Dependents

Marital Status: Single_____ Married_____ Widowed_____ Separated_____ Divorced_____

Total Number of Dependents (Including yourself): __________

List the people you actually support and your relationship to them

Person #1: ______________________ Relationship: ____________________
Person #2: ______________________ Relationship: ____________________
Person #3: ______________________ Relationship: ____________________
Person #4: ______________________ Relationship: ____________________
Person #5: ______________________ Relationship: ____________________
Person #6: ______________________ Relationship: ____________________
Person #7: ______________________ Relationship: ____________________

Insurance

Please provide current information regarding the patient's medical coverage.

Company: ____

Address: ____

____

____

Policy Number: ____

Effective Date: ____

Please indicate if the patient does not have insurance: ________________________________

Signature and Authorization

I certify that the information given on this form is accurate to the best of my knowledge. I understand that providing false or intentionally misleading information on this application will result in disqualification from consideration for any financial hardship relief and may result in collection efforts, up to and including lawsuit, to be initiated. I authorize Professional Services of KU Med., to verify information contained in this application with third parties and hereby release Professional Services of KU Med., and its employees from any undesirable consequences impacting me that may result from such verification and review process.

Signature of Patient: ____

Signature of Responsible party (If different than patient): __________________________________

Date: _______________________________________