LMH Health

A partner for lifelong health

Financial Assistance Program

Program Guidelines

Consistent with its mission to be a partner for lifelong health, LMH Health (LMH) is committed to providing financial assistance to individuals in need of medically necessary treatment who are unable to pay.

Eligibility Requirements

- Must reside within the LMH Health service area and be a United States Citizen or Permanent Resident Alien.
  - Exception: Any patient that presents with an emergent need for care, will be eligible to apply for assistance.
- Financial assistance is only available for services deemed to be medically necessary. Cosmetic and LMH Save procedures and are not eligible for assistance.
- **All applicants are required to apply for any available assistance (including but not limited to Medicare, Medicaid, Veterans Administration, private health insurance, copayment assistance, pharmaceutical assistance programs, medical device assistance programs, etc.) which may be available for payment of services and will take any action reasonably necessary to obtain such assistance.**
- Accounts over 240 days old since first billing or for which LMH Health took legal action are not eligible.

Required Documentation

The following documentation is required in order for the application to be processed. If you do not provide supporting documentation within 30 days, LMH Health will deny your application.

Required documentation include but are not limited to; *(please submit all that pertain to your household):*

- ☐ Proof of *Gross Monthly* income (most recent two month's paycheck stubs).
- ☐ Proof of Support (spousal, alimony or child).
- ☐ Proof of Social Security / Disability / Unemployment received / Food Stamps.
- ☐ Proof of Residency in LMH Health Market Area (utility bill, lease).
- ☐ Proof of Pension, Rental Income, Other Income.
- ☐ Proof of Full-Time Student status.
- ☐ Current detailed bank statements for Checking, Savings or Investment accounts for last three months.
- ☐ Most recent Federal Tax Return (copy of your 1040, 1040A or 1040EZ and schedules).
  ** If listed as a dependent on another person's tax return – we will need a copy of that return as well.*
- ☐ W2 / 1099 Forms.

Federal Poverty Guidelines

LMH utilizes a sliding scale based on the Federal Poverty Guidelines, as published in the Federal Register as the basis for approval of applications. The current guidelines are online at:
https://www.federalregister.gov/documents/2026/01/15/2026-00755/annual-update-of-the-hhs-poverty-guidelines

Participating Providers

This is a list of physician practices that LMH Health bills for and will honor your financial assistance discount:

LMH Health

Primary Care

- LMH Health Primary Care – 6th & Folks
- LMH Health Primary Care – 6th & Maine
- LMH Health Primary Care – Baldwin City
- LMH Health Primary Care – East Heights
- LMH Health Primary Care - Eudora
- LMH Health Primary Care – Free State
- LMH Health Primary Care - McLouth
- LMH Health Primary Care – South Iowa Street
- LMH Health Primary Care - Tonganoxie
- LMH Health Primary Care – West Campus

Non-LMH Affiliated Practices

- Lawrence Clinical Laboratory
- Lawrence Emergency Medicine Associates
- Lawrence Surgery Center

Specialty Care

- Lawrence Endocrinology
- Lawrence General Surgery
- Lawrence GI Consultants
- Lawrence Neurology Specialists
- Lawrence OB-GYN Specialists
- Lawrence Pulmonary Specialists
- Lawrence Spine Care
- Lawrence Urology Specialists
- LMH Health Cancer Center
- LMH Health Heart Center
- LMH Health Pain Specialists
- LMH Health Therapy Services
- LMH Health Women's Center
- LMH Psychiatric Consultation Service
- OrthoKansas
- Palliative Support Services
- Plastic Surgery Specialists of Lawrence
- Sunflower Pelvic Health
- Vein Care at LMH Wound Healing Center

Our Financial Counselors

If you have any questions concerning this application or the process, please contact your Financial Counselor below:

Last Name Starts With	Financial Counselor	Phone Number
A – E	Jessica	(785) 505-5777
F – P	Mary	(785) 505-5788
Q – Z	Dave	(785) 505-5782

Applications will process in approximately 15 business days after receipt of completed application and all required documentation. You will receive an approval or denial letter in the mail.

Please return completed application and documents to:

LMH Health – Patient Financial Services
Attn.: Financial Counselors
325 Maine Street
Lawrence, KS 66044

Received by PFS:_____

LMH Health

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name / Responsible Party / Guarantor's Information ***					
Last Name:	First Name:		M.I.	Date of Birth:	
Address:	City:		State:	Zip Code:	
Employer:	Social Security No.:		Telephone No.: ( )		
Employer's Telephone No.: ( )	Full-Time:	Part-Time:	Hours per Week:	Hourly Wage: $	☐ Weekly ☐ Bi-Weekly ☐ Monthly

Spouse's Information					
Last Name:	First Name:		M.I.	Date of Birth:	
Address:	City:		State:	Zip Code:	
Employer:	Social Security No.:		Telephone No.: ( )		
Employer's Telephone No.: ( )	Full-Time:	Part-Time:	Hours per Week:	Hourly Wage: $	☐ Weekly ☐ Bi-Weekly ☐ Monthly

Please list all dependents (those individuals claimed on your tax return, please do not list individuals listed above).

Dependent's Name	Social Security No.	Date of Birth	Relationship to Guarantor

Cash on Hand – please provide your current balance(s). Please attach copies of your bank statements to support.

Type of Account	Guarantor	Spouse
Checking / Savings	$	$
Investment Accounts	$	$
Other	$	$

***** Responsible party / guarantor will typically be the patient, unless the patient is a minor.**

Please flip over

Provide gross income details (prior to deductions) for guarantor and spouse. PLEASE ATTACH ALL DOCUMENTATION.				
Source of Income	**Guarantor (Monthly)**	**Spouse (Monthly)**	**Other (Monthly)**	**Total (Monthly)**
Wages or Self-Employment	**$**	**$**	**$**	**$**
Public Assistance (Food Stamps)	**$**	**$**	**$**	**$**
Social Security / Disability	**$**	**$**	**$**	**$**
Unemployment / Worker's Comp.	**$**	**$**	**$**	**$**
Child Support (Received)	**$**	**$**	**$**	**$**
Pensions	**$**	**$**	**$**	**$**
Other:	**$**	**$**	**$**	**$**
Total Monthly Income:	**$**	**$**	**$**	**$**
Total Yearly Income:			**$**	

I understand this application is for evaluation of financial assistance based on the Financial Assistance Policy of Lawrence Memorial Hospital. I certify that the above information is true and accurate to the best of my knowledge. ***Further, I acknowledge that my information will be screened for public assistance (Medicaid, Medicare, Insurance, etc.) and I will take any action reasonably necessary to obtain such assistance.*** I agree to have any information shared with other medical providers associated with Lawrence Memorial Hospital. If any information I have given proves to be untrue, I understand that may deny my application. I further understand, that I must continue making payments on my account(s) while this application is under review.

Responsible Party / Guarantor's Signature	Date	Spouse's Signature	Date