TODAY'S DATE: _____ DUE DATE:_____

CHASE COUNTY COMMUNITY HOSPITAL/CLINIC
APPLICATION FOR FINANCIAL ASSISTANCE

INSTRUCTIONS: Please complete both sides of the application including the signature line on the back page. **Verification of income is REQUIRED** on all amounts listed. Acceptable documentation includes but not limited to: recent tax returns, W-2s, paycheck stubs, bank statements, social security letter or letter from an employer. Patients who submit an incomplete application will be sent a letter identifying and requesting the missing information and if additional information is not received within 30 days the application will be closed. Financial Assistance applications must be completed and turned in to the Business Office within 120 days of the first self-pay statement to be considered. The hospital will grant financial assistance to qualified patients on the self-pay portions of their accounts as long as resources are available to finance such care. Note: Care rendered must not be for experimental, cosmetic, or elective reasons and must be medically appropriate.

HOUSEHOLD INFORMATION

Name_____ SS#_____

Spouse/Significant Other_____SS#_____

Address_____ Phone #_____

City, State, Zip_____ Cell Phone #_____

Other Household Members/Ages _____

INCOME INFORMATION

Self

Employer_____

Address _____

Phone # _____

Monthly Gross Income _____

Spouse/Significant Other

Employer _____

Address _____

Phone # _____

Monthly Gross Income _____

Other Monthly Income: _____ Type: _____

Other Monthly Income: _____ Type: _____

(Other income examples include: SSI, Child Support, Workman's Comp, Unemployment,

Pension, Rent, Alimony, Other contributing members residing in same household, etc.)

If you do not have monthly income, please explain how you take care of your monthly expenses.

_____

_____

FINANCIAL INFORMATION

Banking and Investment:

Checking Balance $_____ Savings Balance $_____

Cert. of Deposit $_____ Stocks/Bonds/Mutual funds $_____

HSA/Flex $_____ Other $_____

ASSETS & LIABILITIES:

	Value	Balance Due
Primary residence	$ _____	$_____
Secondary residence	$ _____	$_____
Vehicle #1 Make_____Year_____	$ _____	$_____
Vehicle #2 Make_____Year_____	$ _____	$_____
Vehicle #3 Make_____Year_____	$ _____	$_____

Other Assets (Including: Artwork, Jewelry, Recreational Vehicles, Campers, Boats, etc.)

_____	$ _____	$_____
_____	$ _____	$_____

Liabilities:

Payment to_____for_____	$_____
Payment to_____for_____	$_____
Payment to_____for_____	$_____
Payment to_____for_____	$_____

Self-employed include:

Trade tools/equipment	$ _____	$_____
Business Real Estate	$ _____	$_____
Business Vehicles	$ _____	$_____

Other Medical Bills:

Provider _____	$_____
Provider _____	$_____
Provider _____	$_____

Comments: _____

_____

_____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any other assistance which may be available for payment of my hospital/clinic charges (Medicaid, Insurance, etc.), and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital/clinic the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for services provided by Chase County Community Hospital. I hereby grant permission to Chase County Community Hospital to investigate the information contained herein.

Signature _____Signature_____Date_____