Kearny County Hospital

Family Health Center

Documents Needed For KCH/FHC Financial Assistance

We will need at least one of the following sources of income.

- ☐ *Current Tax Return *Preferred*
- ☐ *Recent W-2*
- ☐ *Pay Stubs- recent 3 Months*
- ☐ *Disability Income or proof have applied for Disability*
- ☐ *Social Security Paper showing amount received monthly*

Excludes Ultrasounds, Supplies, Devices, Nuclear Medications, MRI, and Outreach Specialist,

** Financial aid applications may be submitted before, during or after an episode of care. The patient/family must submit a completed application within 60 days of the date of service. Determinations of eligibility will normally be made within 30 days of receipt of all required documentation.

Kearny County Hospital
Family Health Center

Financial Assistance Application

Head of Household Information:

Last Name First Name Middle Initial Social Security # Date of Birth

Street Address City State Zip

Mailing Address City State Zip

Please check appropriate box: ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

Home Phone: _____ Work Phone: _____

Employer Information:

Employer Name

Employer Address City State Zip

Please Indicate <u>ALL</u> people living in the household, including applicant. Indicate who you are claiming on your tax return: (Use additional sheet of paper if needed)

Name	Relationship to Applicant	Date of Birth	Social Security Number	Tax Dependent (Y/N)
1.	**Self**			
2.				
3.				
4				
5.				
6.				

Are the Services related to a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No

Is anyone in your household: (Check all that apply)

☐ Pregnant Who? _____

☐ A Victim of a crime than caused injury Who? _____

☐ Disabled Who? _____

☐ Not a U.S. Citizen Who? _____

If LPR (Lawful Permanent Resident) how many years? ___ Immigration status: _____

Do you have or plan to file a personal injury claim to compensate for injuries received? Yes ☐ No ☐

Have you applied for Medicaid? Yes ☐ No ☐

Date Applied: _____ Date Denied: _____

Monthly Household Income Information:

	Patient	Spouse/Co-Applicant
Gross Income (before deductions)		
Self-Employment Income		
Unemployment		
Social Security/SSI (please specify):		
Retirement (Pension, Annuity)		
Alimony or Child support		
Interest and Dividends from Investment Accounts		
Real Estate Rental Income		
Other Income		
Total Income	**$**	**$**
	Total House Hold Income	**$**

Monthly Household Expense Information:

	Total		Total
Mortgage/Rent		Groceries	
Electricity		Car Payment ($)	
Household Gas		Day Care	
Water/Sewer		Child Support/ Alimony	
Phone/ Cell Phone		Student Loans	
Cable/ Internet		Medical Expenses	
		Total Household Expense	**$**

Assets					
Personal Items	**Estimated Value**	**Cash or Cash Equivalent**	**Estimated Value**	**Investments**	**Estimated Value**
Home		Checking Account		Retirement account	
Vehicle		Savings Account		Mutual funds	
Vehicle		Certificates of Deposit		Farm or Business	
Furniture & Equipment		Life Insurance (cash value)			
Second Home or Property		Other			
Other					
Assets Total	**$**				
Liquid Assets Total	**$**				

Liabilities		
Loan Balances	**Estimated Debt**	**Monthly Payment**
Mortgage loan		
Home equity loan		
Car loans		
Real estate loans		
Student loans		
Other loans		
Other Outstanding Debt		
Liabilities Total	**$**	

I am applying for financial assistance with Kearny County Hospital. I understand that it is the expectation of Kearny County Hospital that patients use all of their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this Application and supporting documents are true and complete. By signing this form, I agree to allow Kearny County Hospital to verify my employment for the purpose of determining eligibility for financial assistance. I understand that Kearny County Hospital may require more specific proof of any information on this FAA and supporting documents will be provide upon request. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. Kearny County Hospital reserves the right to re-evaluate and/or reverse any charitable service designation material information is not disclosed, or information was misrepresented or deliberately withheld, or if I (or my heirs)make demand for a file a civil action against a third party for personal injuries or damages)including medical charges/expenses). I understand and agree that any financial assistance granted by Kearny County Hospital may not be used by me or my legal representatives in any negotiations, settlements or lawsuit for the purpose of enhancing an award of monetary damages. Should this occur, I agree that Kearny County Hospital has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that nay hospital that rendered medical services to the patient named above may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

Applicant's Signature Date

Co-Applicant's Signature Date

A Financial Counselor is available Monday through Friday 8:00 am to 5:00 pm. For assistance please call (620)355-7111 ext. 5403. * Se Habla Español.

Return complete application to:

Kearny County Hospital
Attn: Financial Counselor
500 E Thorpe St
Lakin, KS 67860
Fax: 620.355.8627