Community HealthCare System
NE Kansas

Centralia | Corning | Frankfort | Holton | Onaga | St. Marys | Westmoreland

Is this application for future or past services? ☐ Future Services ☐ Past Dates of Service
Where were/are the services being performed? _____ Acct #_____

Patient's Information:

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

Address City State Zip
Please check appropriate box: ☐ Single ☐ Married ☐ Common Law ☐ Separated ☐ Divorced ☐ Widowed

Gender: ☐ Male ☐ Female Language: ☐ English ☐ Spanish ☐ Other

Home Phone Number_____ Work Phone Number_____

Person Responsible for Paying the Bill:

Last Name First Name Middle Initial Relationship to Patient Social Security Number

Name of Insurance Company (VA/Medicare/Commercial/etc.) Effective Date

Please include ALL 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 Patient	Date of Birth	Social Security Number	Tax Dependent (Y/N)
1.	SELF			
2.				
3.				
4.				
5.				
6.				
7.				

Are services related to a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No
Is anyone in your household (Check all that apply)
☐ Pregnant? Who? _____ ☐ Eligible for COBRA Benefits? Who? _____
☐ A victim of a crime that caused injury? Who? _____ ☐ Disabled? Who? _____
☐ Not a US Citizen? Who? _____ If LPR, how many years? _____

Updated 6/15/2017

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Monthly Household Income Information	Person 1	Person 2	Person 3
Name of household member			
Name of employer			
Hours per week worked			
Monthly Income From:			
Wages per hour			
Self-Employment			
Investment Accounts			
Real Estate Rentals			
Unemployment			
Retirement			
Social Security			
SSI			
Alimony/Child Support			
Public Assistance/Food Stamps			
Other Income			
Does anyone in the household have any of the following (Check all that apply)			
☐ Checking Account Balance			
☐ Health Savings Account			
☐ Savings Balance			
☐ CD Account Balance			
☐ Bonds Value			
☐ IRAs, 403(b), 401(k)			
☐ Other Savings & Investments			

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

INFORMATION OBTAINED FROM _____ RELATIONSHIP TO PATIENT_____

I am applying for financial assistance with Community HealthCare System (CHCS). I understand it is the expectation of CHCS 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 CHCS to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to CHCS for this same purpose. I understand that CHCS may require more specific proof of any information on this FAA and supporting documents. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. CHCS reserves the right to reevaluate and/or reverse any charitable service designation if material information is not disclosed, or information was misrepresented or deliberately withheld, or if I (or my heirs) make demand for or 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 CHCS 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 CHCS has the right to reverse any charitable service designation and pursue all charges.

_____ _____

Applicant's Signature Date Co-Applicant Signature Date

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Anyone wishing to be considered for **Financial Assistance** must furnish copies of the following:

____Copies of the last 2 payroll stubs showing wage rate &/or gross wage for all household members.

____ If you are self-employed; please provide the last 2 years of tax returns

____Proof of public assistance income, Social Security or SSI for all household members.

____ Child support payments.

____Proof of income from Workman's Compensation for all household members.

____ Proof of income from Veteran's Benefits for all household members.

____ Proof of income from military family allotments from an absent family member or someone not living in the home.

____ Copies of last 2 complete bank statements.

If you have any questions regarding the items listed above, please do not hesitate to contact
Myrna at 785-889-5089 or a Patient Accounts Representative at 785-889-4657 ext. 2101.

Please be assured that all information submitted to us will be held completely confidential within this office. You will need to continue making payments during this process in order to avoid outside collection activity.

Determination of financial assistance is dependent upon information provided by or for the patient.

Return completed application and required documents to:

Patient Financial Services
Community HealthCare System, Inc.,
PO Box 460
Onaga, KS 66521-0460

Community HealthCare System reserves the right to make further inquiries to verify the information provided. After all information is received, it will be submitted for approval.

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