



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

\_\_\_ Copies of the last 3 payroll stubs showing wage rate &/or gross wage for all household members

\_\_\_ Copies of most recent complete tax return (include all schedules)

\_\_\_ Parent or Guardian's most recent yearly tax return, if applicant is a dependent listed on their tax form and under the age of 25

\_\_\_ Proof of public assistance income, Social Security or SSI for all household members

\_\_\_ Proof of income from Workman's Compensation for all household members

\_\_\_ Proof of income from Veteran's Benefits for all household members

\_\_\_ Copies of last 3 months complete bank statements

Please know that the completed application along with proof of income must be received in order for the application to be considered. We are unable to process or consider applications that are not complete.

Please be assured that all information submitted to us will be held completely confidential within this office.

\*All patients who are approved for full charity will owe a copay for service as follows:

Clinic/Lab/Radiology/Therapy Services	\$25.00	per visit
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Inpatient/Observation/ER Services	\$100.00	per visit
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**Return completed application and required documents to:**

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

If you have any questions regarding the items listed above, please contact the Business Office at **785-889-4657 option 3**

*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.*



**Community  
HealthCare System**  
NE Kansas

Is this application for future or past services?    ( ) Future Services    ( ) Past Dates of Service    MRN \_\_\_\_\_

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<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	<b>SSN</b>	<b>Date of Birth</b>
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<b>Address</b>	<b>City</b>	<b>State</b>	<b>Zip</b>
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Please check appropriate box:     Single     Married     Common Law     Separated     Divorced     Widowed

Gender:     Male     Female                      Language:     English     Spanish     Other

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

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**Person Responsible for Paying the Bill:**

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<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	Relationship to Patient	SSN
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Name of Insurance Company (VA/Medicare/Commercial/Health Share Plan)                      Effective Date

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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.				
2.				
3.				
4.				
5.				
6.				
7.				

Are services related to a workers' compensation or motor vehicle accident claim?     Yes     No

Are you a holder of a health share savings plan? (ie, Christian Health Ministry, Good Samaritan)     Yes     No

Is anyone in your household (Check all that apply)

Pregnant?    Who? \_\_\_\_\_

A victim of a crime that caused injury?    Who? \_\_\_\_\_     Disabled?    Who? \_\_\_\_\_

Not a US Citizen?    Who? \_\_\_\_\_    If LPR, how many years? \_\_\_\_\_



Community  
HealthCare System  
NE Kansas

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			
<b>Does anyone in the household have any of the following (Check all that apply)</b>			
<input type="checkbox"/> Checking Account Balance			
<input type="checkbox"/> Health Savings Account			
<input type="checkbox"/> Savings Balance			
<input type="checkbox"/> CD Account Balance			
<input type="checkbox"/> Bonds Value			
<input type="checkbox"/> IRAs, 403(b), 401(k)			
<input type="checkbox"/> 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 \_\_\_\_\_

Updated 10/20/2020