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 nominal fee for service as follows:

| | | |
|---|---|---|
| Clinic/Lab/Radiology/Therapy Services | $25.00 | nominal fee per visit |
| Inpatient/Observation/ER Services | $100.00 | nominal fee per visit |

## 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.*

Updated 12/19/2022

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

**First Name** **MI** **Last Name** **SSN (optional)** **Date of Birth**

**Address** **City** **State** **Zip**

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

Home Phone ____________________ Cell Phone ____________________ Work Phone ____________________

**Person Responsible for Paying the Bill:**

**First Name** **MI** **Last Name** Relationship to Patient SSN (optional)

Name of Insurance Company (VA/Medicare/Commercial/Health Share Plan) 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 | SSN (optional) | 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? _____________________

Updated 12/19/2022

| 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

Updated 12/19/2022