Financial Assistance Application

For assistance, contact Patient Accounts Representative: Sharon Wachsnicht x 471

Distribution Date:	Return by:

	Applicant (Patient/Guarantor)	Spouse/Partner
Name		
Street Address		
City, State, Zip		
Home Phone Number		
Other Phone Number		
Social Security Number		
Date of Birth		
Occupation		
Employer		
Number in Household		

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Medikan, Insurance, etc.) which is available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this application is made so the hospital can judge my eligibility for financial assistance or an extended payment plan. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Applicant's Signature:	Date:

RELEASE FORM OF INFORMATION

I, _____, give permission for request from information to:
__ Request for Transcript of Tax Return from Dept of Treasury – IRS form 4506-T
__ DCF (Department of Children and Families) to fax a copy of my CPS1, CAP2, Food Stamp Benefit History, and Cash Benefit History to the Clay County Medical Center.
Please fax the information to 785-632-3352/ATTN: _____

Signed: _____ Date: _____ S.S.# _____

Additional Names of household members	Date of Birth	Social Security #	Relationship

Monthly Income Verification – for ALL household members

**Submit proof of income and previous year's tax return*

Wages	$	Self-Employment	$
Social Security	$	Pension	$
Unemployment	$	Workers Comp	$
Alimony	$	Child Support	$
SRS Cash Assistance	$	SRS Food Stamps	$
Rental Income	$	Scholarships	$
Estates/Trusts	$	Gambling/Lottery	$
Dividends or Interest	$	Other	$
		Total:	$ _____

Why are you requesting assistance? _____

_____

What is your payment plan expectation? _____

_____

Application checklist

- Application completed and signed.
- Proof of year-to-date household income - or - the last 3 months' income.
- Most recent Federal tax return filing.
- Third party payer screening complete (as applicable).