



CLAY COUNTY
MEDICAL CENTER

Our Family. Caring for Yours.

Clay County Medical Center
617 Liberty Street
P.O. Box 512
Clay Center, Kansas 67432

PH: (785) 632-2144
FAX: (785) 632-3686
WEB: www.ccmcks.org

Financial Assistance Application

For assistance, contact Patient Accounts Representative: Sharon Wachsnicht at 785-630-2741
or The Midland Group staff at 785-630-5394.

Distribution Date:	Return by:
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	Applicant (Patient/Guarantor)	Spouse/Partner
Name		
Mailing 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, Medicaid, 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:
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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).