

FINANCIAL ASSISTANCE APPLICATION

In order for a patient to be eligible for special financial consideration, this form should be completed and the requested documentation attached, and return all documentation to the UKHS Great Bend Campus ATTN: Patient Accounts - 514 Cleveland St, Great Bend, KS 67530

Applicant’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Account #’s: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouses Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of Family Members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Including you, your spouse, your children, and anyone else residing with you that you support. Also students, regardless of their residence, who are supported by their parents or other related by birth, marriage, or adoption, are considered to be residing with those who support them.)

**INCOME: LIST MONTHLY INCOME FOR YOUR FAMILY FROM:**

|  |  |  |
| --- | --- | --- |
|  | **RESPONSIBLE PARTY** | **SPOUSE** |
| **WAGES BEFORE DEDUCTION’S** |  |  |
| **SOCIAL SECURITY INCOME** |  |  |
| **UNEMPLOYMENT COMPENSATION** |  |  |
| **OTHER – PLEASE LIST:** |  |  |
|  |  |  |
| **TOTAL MONTHLY INCOME** |  |  |

\*\*\*PLEASE ATTACH PROOF OF INCOME (COPIES OF CHECK STUBS, W-2 FORMS, AND INCOME TAX RETURN, ETC.)
IF YOU DO NOT HAVE ANY MONTHLY INCOME FOR YOUR HOUSEHOLD, PLEASE ATTACH AN EXPLAINATION OF HOW YOU ARE MEETING YOUR MONTHLY EXPENSES. \*\*\*



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**MEDICAL EXPENSES**: Please list ALL payments that you make monthly and the approximate amounts left owed. Be as specific and complete as possible.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Medical Providers Name** | **Monthly Payment** | **Balance** |
| **Medical Expenses:** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **TOTAL:** |  |  |  |

 **VALUE** **MONTHLY PAYMENT**

Residence - Rent / Own (Circle One) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List Other Property \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may be eligible for financial assistance if you currently qualify for any of the following:

Please check all that apply:

* + Homeless or receive care from a homeless clinic.
	+ Food Stamps.
	+ Patient is deceased with no known estate.
	+ Family or friends of a patient provide information establishing the patient’s inability to pay.
	+ Patient qualifies for section 8 housing/housing voucher.
	+ Patient or immediate family members qualify for free or reduced priced meals through the National School Lunch Program.
	+ Patient or immediate family members qualify for Women, Infant, and Children (WIC) Program.
	+ Patient or immediate family members receive Low Income Energy Assistance (LIEP).
	+ Excessive Medical Expenses.

I hereby state that the information I have provided is true and complete. I authorize UKHS Great Bend Campus to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for payment of any and all charges incurred for the services rendered.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Responsible Party Signature** **Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**Relationship to Patient**

Financial Counselors are ready to help you and your family with any questions and concerns you may have. Counselors are available Monday through Friday from 8:00 AM to 4:00 PM. Office phone numbers: Vicky (620) 791-5054 or Giselle (620) 791-6844 available for English and Spanish.