Request for Financial Assistance

KIOWA COUNTY MEMORIAL HOSPITAL
GREENSBURG FAMILY PRACTICE
HAVILAND CLINIC

Dear Patient and Family:

In keeping with its mission and core values, Kiowa County Memorial Hospital is committed to providing health care for people regardless of their ability to pay.

Financial Assistance: Medical bills may be difficult to pay. Patients who do not have health insurance and who are unable to pay for all or part of their health care services, may apply for financial assistance by completing and returning this form.

Application Process To apply for financial assistance, complete and return this form to Kiowa County Memorial Hospital/Greensburg Family Practice/Haviland Clinic, 721 W Kansas, Greensburg, KS

The following information must be included with the application:

- Two (2) previous year's Federal Tax Returns – Form 1040 and if self-employed add Schedule C documentation.
- Two (2) previous year's W-2s
- Copies of the most recent income information for each person in the household including pay stubs, Social Security, unemployment, retirement, pensions, etc. (Last 3 months)
- If the household is receiving financial support from family or friends, provide a letter detailing the support from the assisting party. We may also request proof of income depending on the level and duration of support.
- Last 3 Month Bank Statements
- **KanCare determination letter (Medicaid). If you have not applied please do so by calling (620) 723-3321 or stopping in at 116 South Pine, Greenburg KS 67054.**

Questions? Please call our business office
620-723-3341 Monday – Friday 8 a.m. to 5 p.m.

This completed application, including the supporting information, should be returned within 14 days of receipt.

By submitting application for assistance, patients give Kiowa County Memorial Hospital/Greensburg Family Practice/Haviland Clinic consent to make necessary inquiries to confirm financial obligations or references.

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Request for Financial Assistance

I. Patient Information

PATIENT'S NAME LAST	FIRST	MI	SOCIAL SECURITY NUMBER

ADDRESS STREET	CITY	STATE	ZIP	TELEPHONE HOME	WORK

DATE OF BIRTH	PRIMARY CARE PHYSICIAN (PCP)	U.S. CITIZEN ❑ YES ❑ NO

II. Guarantor Information

NAME OF PERSON RESPONSIBLE FOR PAYING THE BILL	RELATIONSHIP

ADDRESS STREET	CITY	STATE	ZIP	SOCIAL SECURITY NUMBER

TELEPHONE NUMBER HOME	WORK	U.S. CITIZEN ❑ YES ❑ NO	DATE OF BIRTH

❑ Please check this box if you have not received services and are applying to pre-qualify.

Have you been approved for Financial Assistance by another Health Care organization? ❑ YES ❑ NO
If yes, please provide name of organization ____

Are you being referred by a physician or surgeon? ❑ YES ❑ NO
If yes, please provide name and phone of number of physician ________________________________

III. Household Information – Please indicate ALL people living in your household, including applicant

use additional paper if needed

Please list anyone living in your household (including yourself). Income includes (pre-tax) wages, child support income, alimony income, rental income, unemployment compensation, social security benefits, or public/government assistance.

HOUSEHOLD MEMBERS	AGE	RELATIONSHIP TO PATIENT	SOURCE OF INCOME OR EMPLOYER NAME	MONTHLY GROSS INCOME PRIOR TO DATE OF SERVICE	INSURED? (circle yes or no) If yes, list insurance (i.e. Blue Cross, PHP, etc.)
1.					Yes or No
2.					Yes or No
3.					Yes or No
4.					Yes or No

If additional space is needed place attached on separate page.

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IV. Required Information – Must be included with this application

Please check that you have included the following:

- Copy of 2 previous year's tax returns
- Income verification showing earnings or pay stubs for all income year to date

V. Authorization

I hereby certify the information contained in the above financial questionnaire is correct and complete to the best of my knowledge.

X ______________________________ ____________________

RESPONSIBLE PERSON'S SIGNATURE DATE