# *Graham County Hospital*
# *Graham County Hospital Clinic*

## Financial Assistance Application Checklist

☐ **Completed application**

☐ **Proof of income (i.e. recent paystub, copy of social security deposit, child support deposit information)**

**If you do not have any monthly income, please explain how you are meeting your monthly expenses.**

_____

_____

_____

_____

☐ **Copy of most recent bank statement, checking and any savings accounts**

☐ **Copy of Kansas Medicaid denial letter (dated within the last 6 months)**

☐ **Copy of last year's filed federal income tax return.**

**If you are not required to file, please explain so below.**

_____

_____

Please submit the completed checklist, application and required documentation to

Graham County Hospital or Clinic

304 W. Prout Street/Hill City, Kansas 67642/(785) 421-2121
114 E. Walnut/Hill City, Kansas 67642/(785)421-2191

# Graham County Hospital Financial Assistance Application

## YOUR CONTACT INFORMATION

First Name _____ Last Name _____

Birth Date _____

Address _____

City/State _____ Zipcode _____

Phone _____ Email _____

Spouse Name _____ Birth Date _____
(if applicable)

**List all other household members:**

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

Name _____ Relation _____

**Total # of household members** _____

**Employment Status**

- ☐ Full/Part time
- ☐ Self Employed
- ☐ Retired
- ☐ Unemployed - seeking job
- ☐ Unemployed - unable to work
- ☐ Other:_____

**If employed, please provide employers name, address and phone number:**

**If employed, please list average hours worked per week:**

**Do you have Health Insurance?**

- ☐ Yes
- ☐ No

| Monthly Income: (Attach copies of Proof of Income) | | | |
|---|---|---|---|
| **Income Type:** | **Responsible Party** | **Spouse** | **Other Members of the Household (18 & Older)** |
| Wages | | | |
| Social Security | | | |
| Pensions | | | |
| Unemployment | | | |
| Workman's Compensation | | | |
| Government Assistance | | | |
| Disability Payments | | | |
| Veteran's Payments | | | |
| Child Support | | | |
| Other Income | | | |
| | | | |
| Monthly Subtotal | | | |
| **Total Income** | **Monthly:** | | |

***I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patients household income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill.***

Patient/Guarantor Signature Date

| **For Office Use:** |
|---|
| Date Completed: |
| Status: ☐ Denied reason:_____<br>☐ Approved % of Discount_____ |
| Staff Signature: |