GOVE COUNTY MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION

520 W 5th Str, Quinter KS 67752 785-754-3341

PATIENT NAME	DATE OF BIRTH	MARITIAL STATUS M S W D	DATE APP RETURNED

PATIENT ADDRESS	GUARANTOR	RELATIONSHIP TO PATIENT
	NAME	
	ADDRESS	PHONE NUMBER
PHONE NUMBER		

LIST ALL MEMBERS OF HOUSEHOLD & RELATIONSHIP TO PATIENT

EMPLOYMENT

PATIENT'S EMPLOYER	GUARANTOR'S EMPLOYER
OCCUPATION	OCCUPATION

HEALTH INSURANCE

ATTACH COPY OF HEALTH INSURANCE OR MEDICAID CORRESPONDANCE OF APPROVAL OR DENIAL

DO YOU HAVE HEALTH INSURANCE? YES NO	HAVE YOU APPLIED FOR MEDICAID ? YES NO	
IF YES, NAME OF INSURANCE	DATE APPLIED	IF DENIED, DATE
	REASON FOR DENIAL	

MONTHLY INCOME

ATTACH COPY OF LAST 2 YEARS INCOME TAX RETURNS, LAST 3 PAY STUBS AND MOST CURRENT BANK STATEMENT

PATIENT	GUARANTOR
GROSS WAGES	GROSS WAGES
SOCIAL SECURITY	SOCIAL SECURITY
PENSIONS	PENSIONS
UNEMPLOYMENT/WORK COMP	UNEMPLOYMENT/WORK COMP
GOVERNMENT ASSISTANCE	GOVERNMENT ASSISTANCE
DISABILITY PAYMENTS	DISABILITY PAYMENTS
OTHER (PLEASE LIST)	OTHER (PLEASE LIST)

FINANCIAL INFORMATION

CHECKING ACCOUNT BALANCE $_____

SAVINGS ACCOUNT BALANCE $ _____

EXPENSES	MONTHLY PAYMENT		HOUSEHOLD ASSETS	VALUE
MORTGAGE OR RENT			RESIDENCE	
CAR PAYMENT			VEHICLE 1	
UTILITIES (GAS, ELECTRIC, WATER)			VEHICLE 2	
CABLE			VEHICLE 3	
PHONE			FARM OR BUSINESS	
GROCERIES			RENTAL	
CHILD CARE			RECREATIONAL (BOAT, RV, ATV)	
CLOTHING			LIVESTOCK	
INSURANCE (AUTO, LIFE, HEALTH)			OTHER ASSETS (PLEASE LIST)	
OTHER EXPENSES (PLEASE LIST)				
			HOUSEHOLD DEBTS	
OTHER PERTINANT INFORMATION REGARDING FINANCIAL SITUATION			HOME LOAN	
			AUTO LOAN	
			CREDIT CARD DEBT	
			OTHER DEBT (PLEASE LIST)	

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, Insurance, etc) which may be 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 uncompensated services under the Hil-Burton Act, based on the established criteria on file in the hospital. If any information I have given proves to be untrue, I undestand the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

APPLICANT SIGNATURE	DATE

APPLICATION DETERMINATION **APPROVED** **DENIED**

AMOUNT OF FINANCIAL ASSISTANCE

REASON FOR DENIAL

DATE APPLICANT NOTIFIED

HOSPITAL REPRESENTATIVE SIGNATURE (S)	DATE
	DATE