Greeley County Health Services

GREELEY COUNTY FAMILY PRACTICE CLINIC
321 E HARPER – PO BOX 640
TRIBUNE, KS 67879
PHONE (620) 376 - 4251
FAX (620) 376 - 2772

GREELEY COUNTY HOSPITAL
506 THIRD STREET – PO BOX 338
TRIBUNE, KANSAS 67879
PHONE (620) 376-4221
FAX (620) 376-2406

WALLACE COUNTY FAMILY PRACTICE CLINIC
504 E 6TH STREET – PO BOX 310
SHARON SPRINGS, KS 67758
PHONE (785) 852 - 4230
FAX (785) 852 - 4364

FINANCIAL ASSISTANCE APPLICATION

For:
Financial Assistance Program

☐ COMPLETED AND SIGNED FINANCIAL ASSISTANCE APPLICATION (front & back)
(application must be signed by all persons requesting assistance)

☐ COPY OF LAST THREE (3) MONTHS WORTH OF PAY STUBS FROM **ALL** PERSONS IN HOUSEHOLD (even if that person is not applying for assistance)

☐ MOST RECENT FEDERAL INCOME TAX RETURN (MUST BE SIGNED) –OR-
PREVIOUS YEAR'S W2 FORMS FROM **ALL** PERSONS IN HOUSEHOLD
(even if that person is not applying for assistance)

☐ PATIENT AUTHORIZATION SIGNED
(Must be signed by all persons requesting assistance)

☐ PROOF OF RESIDENCY
(i.e Most recent utility bill)

PLEASE NOTE:

ALL BOXES MUST BE CHECKED IN ORDER FOR YOUR APPLICATION TO BE VIEWED. YOUR APPLICATION WILL NOT BE CONSIDERED UNTIL ALL INFORMATION HAS BEEN SUBMITTED AND COMPLETED. IT IS UNDERSTOOD THAT OTHER DOCUMENTATION MAY BE REQUESTED TO FURTHER ASSIST IN YOUR ELIGIBILITY DETERMINATION.

IF APPROVED, THE FINANCIAL DISCOUNT IS EFFECTIVE FOR 6 MONTHS.

Submit completed application packet (with supporting documentation) within 14 days to:

Greeley County Health Services
Attn: PATIENT FINANCIAL ASSISTANCE COORDINATOR
PO Box 640
Tribune, Kansas 67879
Fax: (620) 376-2800

IF ALL REQUIRED INFORMATION IS NOT RECEIVED WITHIN FOURTEEN (14) DAYS UPON RECEIPT OF APPLICATION, APPLICATION WILL AUTOMATICALLY BE DENIED.

IF YOU HAVE ANY QUESTIONS REGARDING FINANCIAL ASSISTANCE, PLEASE CONTACT THE PATIENT FINANCIAL ASSISTANCE COORDINATOR AT: Tribune 620-376-4251 or Sharon Springs 785-852-4230.

FINANCIAL ASSISTANCE APPLICATION

In order for us to assist you financially, it is important that you provide us with the following information regarding your income and assets. This questionnaire is designed to assess your needs and remains confidential. If you have any questions with this form, please contact the Patient Financial Assistance Advocate at 620-376-4251 in Tribune, KS or 785-852-4230 in Sharon Springs, KS.

Applicant(s) Name: _____ Date:_____

Mailing Address: _____

City/St: _____ Zip: _____

Home #: (_____) _____ Cell phone #: (_____) _____

e-mail address: _____

NOTE: BY PROVIDING THIS INFORMATION I AM GIVING CONSENT TO CONTACT ME AT THESE PHONE NUMBERS AND/OR E-MAIL ADDRESS AND GIVE CONSENT THAT MESSAGES MAY BE LEFT FOR ME THERE.

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. Tell us about everyone living in your home. How many people are in your household? _____
(include everyone that lives with you – list everyone that has meals with you)

	Name	Relationship	Date of Birth	Age
1				
2				
3				
4				
5				
6				
7				

***Use a separate sheet of paper if you need more space.*

Is anyone in your household pregnant? ____Yes ____No. If yes, what is that person's age: _____

2. Tell us about your income: Proof of income, before deductions, is required. Does anyone in your household have a job or is self-employed? (if self-employed, please provide a copy of the business income/loss from the most recent federal income tax return and, also, a statement of income & expenses from the last three months)

   a. If yes, *please list those who are employed in the household and provide proof of income* with this application. (This includes your children, if they are employed)

Name	Employer	Dates of Employment

   b. If no, submit the last pay stub from your last employer and indicate the last date of employment: _____

3. Does any family member receive any other income that was not listed above?

Type of Income	**Circle One**	**Amount/ Month**
Social Security	Yes or No	$_____
Other Income	Yes or No	$_____
Retirement/Pension Benefits	Yes or No	$_____
Child Support or Alimony	Yes or No	$_____
Unemployment Compensation	Yes or No	$_____
Income from Dividends, Interest Royalties	Yes or No	$_____
Public Assistance Payments	Yes or No	$_____
Regular Insurance or Annuity Payments	Yes or No	$_____
Worker's Compensation	Yes or No	$_____

4. If you have no source of income, who is supporting you? _____.

   How do you pay your bills? _____.

5. Are you currently paying for any health insurance coverage? Yes or No.

If yes, what is your monthly premium? _____

What is your annual deductible/co-insurance amount? _____

6. If no, have you applied for Medicaid coverage? Yes or No. Were you accepted / denied?

If yes, but have yet to hear a response, what day did you submit the application?

_____ ***(Please include a copy of your application if you have not heard a response)***

(***If you were denied, include a copy of the denial letter you received with this application).***

7. Have you applied for insurance through the Health Care Exchange program at healthcare.gov? Yes or No. If not would you like assistance in doing so? Yes or No.

8. Have you ever applied for social security? Yes or No.

If yes, what was the outcome? _____

(If yes but were denied, include a copy of the denial letter you received with this application).

9. Do you feel you are disabled, unable to work for the next 12 months? Yes or No.

If yes, have you applied for disability benefits through your local SRS office? Yes or No.

If no, explain why: _____

_____

_____

_____

10. Does any household family member have any assets listed below:

ASSETS:	**CIRCLE ONE:**	**VALUE/AMOUNT:**
Cash	Yes or No	$_____
Credit Cards	Yes or No	$_____
Source of Available Credit	Yes or No	$_____
Savings Accounts	Yes or No	$_____
Checking Accounts	Yes or No	$_____
Stocks or Bonds	Yes or No	$_____
Real Estate	Yes or No	$_____
Automobiles	Yes or No	$_____
Recreational Vehicles	Yes or No	$_____

11. Does any household family member have one or more vehicles (examples; automobiles, boats, recreation vehicles, etc.)? Yes or No.

Name or Owner Year & Model Owned/Making Payments

_____

_____

_____

_____

ADDITIONAL COMMENTS: (PLEASE PROVIDE ADDITIONAL INFORMATION THAT SUPPORTS YOUR REQUEST AND EXPLAINS YOUR FINANCIAL SITUATION.) (LIST ANY EXPENSES YOU WANT CONSIDERED and any information that will help us determine your need).

_____

_____

_____

_____

_____

_____

I understand that my case record is confidential and no information will be released from it unless properly authorized by me.

I, certify that I have or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any on information regarding any situation, I am subject to automatic denial from the financial assistance program and possible prosecution for fraud. By signing this application, I am authorizing the release of any information needed to determine my eligibility, not to exclude address verification, a credit check through national credit bureau, an asset check through the County Tax Assessor, and verification of all benefits listed.

_____ _____

Applicant Signature **Date**

_____ _____

Applicant Signature **Date**

***Signatures also required on following page.**

PATIENT AUTHORIZATION

I allow my doctor(s), any health care providers, the patient financial assistance advocate, and my health plan or insurers to give medical information relating to my use or need for products or services provided under the Greeley County Health Services Financial Assistance Programs.

I understand:

- This information can include spoken or written facts about my health and payment benefits.
- It can include copies of my health records.
- People who work for GCHS may see my information but they may use it only to help me get assistance with the costs of my drugs, assistance with my sliding fee discount application, or assistance with my financial assistance , and to run the program.
- Every effort will be made to keep my information private, but if it is accidentally given out, federal privacy laws will not protect it.
- GCHS reserves the right without notice to change the application form, change the program or program criteria or stop assistance provided by the program at any time.
- Information may be requested and obtained about my or my family's income.
- I can withdraw this consent at any time, but it will not change any actions taken before I withdrew consent.
- Completing this application form does not guarantee that I will qualify for any programs offered by the GCHS Financial Assistance Program.
- This authorization will last until I am no longer participating in the GCHS Financial Assistance Program.

I authorize the GCHS Patient Financial Assistance Coordinator to communicate with providers and insurers on my behalf.

I KNOW THAT I MAY REFUSE TO SIGN THIS FORM. My choice about whether to sign this form will not change the way health care providers or insurers treat me. If I refuse to sign this form, I know that this means I may no longer be able to receive assistance from the GCHSFinancial Assistance Program.

_____ _____

Patient Signature Date

_____ _____

Patient Signature Date