NORTON COUNTY HOSPITAL

Financial Assistance Application

In our mission to serve the healthcare needs of residents of Norton County, Norton County Hospital (NCH) is committed to making care affordable. NCH offers discounts, payment options and financial assistance to people who cannot afford to pay for medical care, including Emergency Department services. NCH offers medically necessary services in our facility at a discounted rate or free of charge if you are an eligible candidate under the Financial Assistance Program (FAP).

The financial assistance program applies to all medically necessary hospital inpatient, outpatient and Emergency Department services that are billed by NCH. The applicant must demonstrate an inability to pay in accordance with the income criteria as established by the current Federal Poverty Guidelines (FPG).

The Financial Assistance policy and procedure is available on request from the NCH Business Office or available on the NCH website.

Instructions: All questions must be answered. If a question does not pertain, write N/A on the line.

_____ Date	_____ Account No. or Social Security No and Date of Birth
_____ Patient Name	_____ Employer
_____ Street Address	_____ Spouse
_____ City, St, Zip	_____ Spouse Employer
_____ Phone Number	_____ Email address

Citizenship (check one): ☐ U.S. Citizen ☐ Non-US Citizen

Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/er

Patient	Spouse/Guarantor
☐ Employed Full Time	☐ Employed Full Time
☐ Employed Part Time	☐ Employed Part Time
☐ Not Employed/Retired	☐ Not Employed/Retired

Names of Dependents (legal deductions on your tax return) Number in household _____

Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	
Name:		Relationship:		Date of Birth:	
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Other Coverage options Have you applied for Medicaid in Kansas? ☐ Yes ☐ No

Have you applied for a loan to cover your services? ☐ Yes ☐ No

Housing (check one) ☐ Own ☐ Rent ☐ Paid House Payment $_____/month

Utilities Electricity $_____/month Gas $_____/month Water $_____/month

Automobiles Own (How many?)_____ Lease (How many?)_____ Car Payment(s): $_____/month

Bank Accounts/Other Assets **(must answer all three questions)**

Checking Account? ☐ Yes ☐ No $_____

Savings Account? ☐ Yes ☐ No $_____

Additional Assets? ☐ Yes ☐ No Describe _____

Income

Attach a photocopy of #1 or #2 and one of the remaining proofs of income with the completed form:

1. **Last year's tax return statement**
2. **Social Security check, summary or award letter**
3. **Last 2 paycheck stubs**
4. **Unemployment, Food Stamp summary**
5. **Letter from employer – on letterhead (to include employee name, hourly wage, number of hours worked)**
6. **Bank statement showing direct deposit for child support or copy of child support history report**
7. **Self-employed/farmer – balance sheet/statement of assets and liabilities**
8. **COPY OF MEDICAID DENIAL LETTER MUST BE ATTACHED TO APPLICATION**

Income:	$	/per month	Pension:	$	/per month
Spouse Income:	$	/per month	Farm or Self Emp:	$	/per month
Social Security:	$	/per month	Public Assistance:	$	/per month
Alimony:	$	/per month	Child Support:	$	/per month
Trust Fund:	$	/per month	Survivors Benefit:	$	/per month
Unemployment:	$	/per month	Workman's Comp:	$	/per month
Dividends, Interest, Rent:	$	/per month	Other Income:	$	/per month
			TOTAL INCOME:	**$**	**/per month**

(Approval requires proof of income with application)

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. Norton County Hospital retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to Norton County Hospital to obtain information from any source to verify the statements I (we) have made.

_____ _____
Patient / Guarantor Signature Date

_____ _____
Administrative Signature Date