CLARA BARTON HOSPITAL/CLINICS
Hoisington, KS 67544

Clara Barton Hospital has a program that is available to assist patients who are legal United States Citizens with their financial medical needs. The following information will need to be completed with all needed information in order to be processed.

FINANCIAL ASSISTANCE PROGRAM

Enclosed you will find an application for Financial Assistance for your Clara Barton Hospital and Clinics accounts. Please review the application completely **and attach all requested information.** If you are married, please be sure that you and your spouse sign the application. **The entire application must be filled in. If a section asks you to include paperwork, you must include the paperwork but that section also must be filled in. If a section does not apply to you, please do not leave that section blank but instead write N/A. If you are not working, please provide proof of income supporting you and your family. Incomplete applications will be returned.**
We have Financial Counselors that are available to assist you with questions you may have concerning the application. After the application is received (with all requested information), it will be reviewed and you will be notified if you are eligible for financial assistance towards your accounts with Clara Barton Hospital and Clinics.

If you have any accounts with the collection agency and court costs and fees have been attached, you will need to pay those costs and fees before the application is processed.

Please call a Financial Counselor for an appointment within the next ten days:
Applications will not be accepted at the front desk. You must bring it personally to a Financial Counselor at the time of your scheduled appointment. Please bring your completed application and all requested information at that time and we will go over the form and make copies of the needed information. If you need help filling out the form, one of the Financial Counselors will be glad to help you. If you have any questions, please call @Hosp-Kelli at 620-653-5038 or Jennie at 620-653-2114 ext 1318 and @ Clinic-Clara at 620-653-5054 or Cheryl at 620-653-2386 ext 1254.

CLARA BARTON Hospital
250 West Ninth
Hoisington, Kansas 67544

FINANCIAL ASSISTANCE APPLICATION

Last Name	First Name	Middle Initial
Address	**City**	**State\Zip**
Home Phone Number	**Work Phone Number**	

Are you a legal United States Citizen? **Yes** **No**

please circle

1) Please list all persons residing in your household.

Name	Relationship	Date of Birth	SSN

2) Please attach a copy of your insurance card or NA if you have no insurance.

Name of Insured	Insurance Company\Contact	Policy\Group Number	Expiration Date

3) Have you applied for Medicaid or other State\County Assistance? **Yes** **No**

Please circle

4) If yes, Please list the Name of Agency and with whom you are working.

Agency Name	Worker	Number

4) a. Are you participating in the Discount Fee program at Clara Barton Medical Clinic?

Yes **No**

please circle

5) **Do you have the following? Please check yes or no to all that apply.**

If yes, please provide a copy of the most recent months statement on those accounts.

If you have other resources not listed please write them in or attach on separate sheet.

Yes	No	Type of Account	Bank \ Assoc.	Name on Account	Account Number	Balance
		Checking				
		Checking				
		Savings				
		Savings				
		CD				
		IRA				
		Stocks\Bonds				
		Trusts				

6) **Please list Vehicles, Homes, Land, Recreational or other property in this section. If none please mark NA.**

Yes	No	Property Type	Year	Model	Current Value	Balance

7) **Do you rent your home?** **Yes** **No**

If yes, please complete the section below.

Landlords Name **Landlords Address** **Landlords Phone Number**

8) **Have you ever filed for bankruptcy?** **Yes** **No**

Please circle

If yes, Please indicate below.

Date filed: _____ **Type:** _____

9) **Please attach a copy of your recent tax return along with ALL schedules AND W2's.**

10) Please list the following information for all persons working in your home.

Please attach a copy of your paystubs or statement from your employer of your past three months wages.

Person Employed	Name and Address of Employer	Wages per hour	# Hours per wk	Pay Dates	Next pay date	Hire Date

11) Is anyone in the household Self-employed?

Yes **No**

Please circle

If yes, Please complete the following information.

Person Self Employed	Type of Self Employment	Weekly Income	Weekly Expenses	Date Started

12) If not currently employed please complete the following information for all adult household members.

Person previously employed	Previous Employer Name and Address	Last Check Date	Reason for leaving

13) Does anyone in your household receive any Unearned income?

Please attach a copy of verification of receipt of this income.

	Name of Recipient	Amount Rec'd	How Often	Account or Recipient #
Alimony				
Child Support				
In-Kind gifts				
IRA\Dividends				
Retirement				
Social Security				
Social Security				
Student Financial Aid				
Unemployment				
Veterans Benefits				
Workman's Comp				
Food Stamps				
Other				

14) Please list your current monthly expenses.

Please list any other expenses not already listed. Provide a copy of your most recent bill.

Description of Expense	Paid to\Account #	Amount you pay	Amount paid by others
Rent\Mortgage			
Electric			
Gas Bill			
Food			
Cable			
Insurance Car			
Life			
Propane			
Telephone Home			
Cellular			

15) Please list any other payments your household may make.

Please list any other expenses not already listed. Please provide a copy of proof of payment.

Description of Expense	Paid To\Account #	Amount you pay	Amount paid by others
Alimony			
Bank Loans			
Charge Cards			
Child Care			
*Child Support			
Medical expenses			
Medication			

****If you pay child support please list your court order number in the account column.***

16) What monthly payment do you feel you can make? _____

Please review your application and be sure to provide copies of all requested information. If you have any questions regarding your application please contact:
@hosp Kelli 620-653-5038 or Jennie 620-653-2114x1318 @clinic Clara 620-653-5054

Acknowledgement of Responsibility:

By signing this application you are agreeing that you have completed this application and the information herein is true and accurate. If any information given in the application process proves to be untrue, Clara Barton Hospital and Clinics reserves the right to re-evaluate the financial status of the application and take whatever action becomes appropriate including reversing the decision to allow charity care. You also understand that the information submitted is subject to verification; and therefore grant permission and authorize any Bank, Insurance Co., Financial Institutions, Federal or State agencies and credit grantors of any kind to disclose to any authorized agent of Clara Barton Hospital and Clinics information as to your past and present accounts.

_____ _____

Signature of Applicant **Date**

_____ _____

Signature of Spouse **Date**