321 E. Harper St.
P.O. Box 640
Tribune, KS 67879

Phone: 620-376-4251 Ext. 213
Fax: 620-376-2800

Greeley County Health Services

504 E. 6th St.
P.O. Box 310
Sharon Springs, KS 67758

Phone: 785-852-4230 Ext. 304
Fax: 785-852-4364

FINANCIAL ASSISTANCE/ MEDICAL HARDSHIP APPLICATION

☐ COMPLETED AND SIGNED APPLICATION

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

OR

☐ MOST RECENT FEDERAL INCOME TAX RETURN (MUST BE SIGNED) OR W2 FORMS FROM **ALL** PERSONS IN HOUSEHOLD(even if that person is not filing for assistance)

☐ PATIENT AUTHORIZATION SIGNED

PLEASE NOTE*: *ALL BOXES MUST BE CHECKED IN ORDER FOR YOUR APPLICATION TO BE VIEWED. **YOUR APPLICATION MUST BE FILLED OUT IN ITS ENTIRETY.** APPLICATIONS WILL BE DELAYED FOR PROCESSING IF ANY REQUIRED INFORMATION IS MISSING OR INCOMPLETE.

Submit application & requested documents to:

Greeley County Health Services
Attn: Connie Rupp
P.O. Box 640
Tribune, Kansas 67879

If approved, the financial discount is effective for 1 year. Once it is expired, a new application is required for dates of service after that date.

IF YOU ANY QUESTIONS REGARDING FINANCIAL ASSISTANCE, PLEASE CONTACT Connie Rupp, Patient Financial Assistance Coordinator at 620-376-4251 ext. 213 OR 785-852-4230 ext. 304.

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. 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 Coordinator at 620-376-4251 Ext. 213 in Tribune, KS or 785-852-4230 Ext. 304 in Sharon Springs, KS.

Applicant Name: _____ Date:_____

Mailing Address: _____ City/St: _____ Zip: _____

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

Email address: _____

Is this is a renewal application? Yes ____ No ____ My previous sliding fee expired on: _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. Tell us about everyone living in your home. How many people are in your household? _____
(**include yourself** and everyone that lives with you)

	Name	Relationship	Date of Birth	Age
1				
2				
3				
4				
5				

***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. Does anyone in your household have a job or is self-employed? Yes ____ No ___ (if self-employed, please provide a copy of the business income/loss from the recent federal income tax return **and** a statement of income & expenses from the last 3 months)

   a. *Please list ALL who are employed in the household and provide proof of income*.

   Name Employer Dates of Employment

   _____

   _____

   _____

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

_____

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

If Yes, please explain _____

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

How do you pay your bills? _____

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

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

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

ADDITIONAL COMMENTS: ***(*****PLEASE PROVIDE ADDITIONAL INFORMATION THAT SUPPORTS YOUR REQUEST AND EXPLAINS YOUR FINANCIAL SITUATION.** ***)***

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 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**

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 GCHS Financial Assistance Program.

_____ _____

Patient Signature Date

_____ _____

Patient Signature Date