HOSPITAL DISTRICT #6

Anthony Campus
1101 E. Spring ▪ Anthony, KS 67003
620-842-5111

Harper Campus
700 W. 13th St. ▪ Harper, KS 67058
620-896-7324

TOGETHER for a Healthy FUTURE

Uncompensated Care Application

The attached information is necessary for us to reach a decision regarding your account(s). Failure to supply requested information could hinder processing and may result in your account(s) being sent to collections. Information received will be regarded as confidential and used only for determining financial status.

Please include the following information with your application to aid us in determining your financial status:

1. Present source of income (copy of last four paycheck stubs) or statement from employer verifying wages.
2. IRS W-2 issued during the past year or most recently filed IRS Tax Form (for example, 1040, 1040EZ).
3. Last two months entire bank statements for checking, savings, money market, and investment accounts.
4. Written Statements for the most recent two months for all other income (Unemployment Compensation, disability, retirement, in-kind assistance etc.)
5. Unemployment Denial Letter, if applicable.
6. Contribution statements from individuals who contribute income or in-kind assistance to the patient.

Please return application to the Anthony or Harper Campus business office. If you have questions or concerns, please contact the business office at Anthony Campus at (620) 842-5111, extension 121 or at Harper Campus 620-896-7324, ext. 291.

I hereby request that Hospital District No. 6 of Harper County, KS make a written determination of my eligibility for financial assistance. I certify that all information is true and correct to the best of my knowledge. I understand that the information given will be used to ascertain my ability to pay for services provided by Hospital District No. 6 of Harper County, KS Anthony and Harper Campus and any associated clinics. I grant permission for Hospital District No. 6 of Harper County, KS to verify the information provided herein and authorize my employer/institution to release such information.

Signature _____ Date _____

Section I – Contact Information

Patient Name _____

Guarantor Name _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Employer _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Spouse Name _____

Spouse Employer _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Section II – Monthly Income

Source	**Amount**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Total Monthly Income	_____

Section III – Monthly Expense

Expense Item	Bank/Company	Balance	Monthly Payment
Home Mortgage			
Vehicle Loan #1			
Vehicle Loan #2			
Credit Card #1			
Credit Card #2			
Medical Bills			
Other Loan(s)			
Rent Payment			
Auto Insurance #1			
Auto Insurance #2			
Utilities (Electric)			
Utilities (Gas)			
Telephone			
Cell Phone			
Cable/Satellite TV			
Internet Service			
Groceries			
Child Care			
Auto Fuel			
Life Insurance			
Other			
Total Monthly Expenses			

Section IV – Summary

Total Monthly Income	
Total Monthly Expense	
Income Less Expense	

Please provide any comments, details, or circumstances that you would like us to be aware of:

For Hospital/Clinic Use Only

SEE ATTACHED PRINTOUT FOR ITEMIZATION OF ACCOUNTS.

Date application received by hospital/clinic _____

Received by: _____ Date:_____

Amount of payment Approved:

Hospital $_____

Clinic $_____

Reason for Denial _____

Date of approval or denial by CFO _____

Date of approval or denial by Finance Committee _____

_____
Chief Executive Officer