**In order for a patient to be eligible for special financial consideration, this form should be completed and the requested documentation attached, and the form be returned to the**

**Great Bend Regional Hospital att: Kathy Shull. -514 Cleveland St Great Bend, KS 67530**

Applicant’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State­­­­\_\_\_\_\_\_\_\_\_\_\_ Zip­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone#(\_\_\_\_\_\_\_\_  ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Account #(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone# (\_\_\_\_\_\_\_\_\_ )\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long \_\_\_\_\_\_\_\_\_

Spouse’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How Long\_\_\_\_\_\_\_\_\_

Number of Family Members­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Including you, your spouse, your children, and any one residing with you that you support. Also students, regardless of their residence, who are supported by their parents or other related by birth, marriage, or adoption, are considered to be residing with those who support them.)

**INCOME: LIST MONTHLY INCOME FOR YOUR FAMILY FROM:**

|  |  |  |
| --- | --- | --- |
|  | **Responsible Party**  | **Spouse**  |
| **Wages Before Deduction’s**  |  |  |
| **Social Security Income** |  |  |
| **Unemployment Compensation**  |  |  |
| **Other- Please List** |  |  |
|  |  |  |
| **Total Monthly Income** |  |  |

\*\*\*PLEASE ATTACH PROOF OF INCOME (COPIES OF CHECK STUB’S, W-2 FORMS,

INCOME TAX RETURN, ETC.)

IF YOU HAVE NO MONTHLY INCOME, PLEASE ATTACH

AN EXPLANATION OF HOW YOU ARE MEETING YOUR MONTHLY EXPENSES. \*\*\*

**MEDICAL EXPENSES: LIST ALL PAYMENTS YOU MAKE MONTHLY AND APPROXIMATE AMOUNT(S) LEFT OWING. BE AS SPECIFIC AND COMPLETE AS MUCH AS POSSIBLE.**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Medical Providers Name** | **Monthly Payment** | **Balance** |
| **Medical Expenses** |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Total** |  |  |  |

 VALUE MONTHLY PAYMENT

Residence- Rent / Own (Circle One) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Property \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may be eligible for financial assistance if you currently qualify for any of the following:

Check all that apply-

* Homeless or receive care from a homeless clinic
* Food Stamps
* Patient is deceased with no known estate
* Family or friends of a patient provide information establishing the patient’s inability to pay
* Patient qualifies for section 8 housing/housing voucher
* Patient or immediate family member(s) qualify for free or reduced priced meals through the National School Lunch Program
* Patient or immediate family member(s) qualify for Women, Infant and Children (WIC) Program
* Patient or immediate family member receives Low Income Energy Assistance (LIEP)
* Excessive Medical Expenses

I hereby state that the information I have provided is true and complete. I authorize **Great Bend Regional Hospital** to verify this information, including requesting a credit bureau report. I understand that if any of this information is determined to be deceptive or false, I may be denied special financial consideration and I will be liable for payment of any and all charges incurred for the services rendered.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient

Financial Counselor Kathy Shull is ready to help you and your family with any questions and concerns you may have. **Kathy is available Monday through Friday from 8:00am to 4:00pm at 620.791.6228**