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**	

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.

If you received only emergency room or ancillary services you may skip this section.

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.

If you received only emergency room or ancillary services you may skip this section.

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**