McPherson HOSPITAL

1000 Hospital Drive
McPherson, KS 67460
877-803-6675

Dear Patient:

Thank you for choosing McPherson Hospital for your health care needs.

The attached form will allow you to apply for financial assistance. Please carefully fill out the form and be sure to include proof of income and resources in order to qualify. If you do not return the form within 30 days of receiving it, or you do not provide valid proof of your income, your application may be denied.

You must submit at least:

- Proof of Kansas Residency (copy of utility bill, etc.)
- Copy of most recent tax return, or not filing statement
- Three most recent pay stubs from each earner in the household
- Copy of most recent bank statements of all current accounts
- Other documentation that proves income (child support, retirement, SSI, etc.)

Applications can be returned to:
McPherson Hospital
Haase & Long Office
Attn: Haase & Long Charity Program
1000 Hospital Dr.
McPherson, KS 67460

Feel free to contact us if you have questions.

Sincerely,

McPherson Hospital Charity Program

Financial Assistance Application
McPherson Hospital Inc.

Is this application for future or past services? ☐ Future Services ☐ Past Dates of Service

Acct#_____

Patient's Information:

Last Name First Name Middle Initial Social Security Number Date of Birth

Street Address City State Zip

Mailing Address City State Zip

Please check appropriate box: ☐Single ☐Married ☐Common Law ☐Separated ☐Divorced ☐Widowed

Gender: ☐Male ☐Female Language: ☐English ☐Spanish ☐Other

Home Phone Number _____ Work Phone Number _____

Person Responsible for Paying the Bill:

Last Name First Name Middle Initial Relationship to Patient Social Security Number

Name of Insurance Company (VA, Medicare, Commercial, AFLAC, etc.) Effective Date

Please indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return: (Use additional sheet of paper if needed)

NAME	RELATIONSHIP TO PATIENT	DATE OF BIRTH	SOCIAL SECURITY NUMBER	TAX DEPENDENT(Y/N)
1.	Self			
2.				
3.				
4.				
5.				
6.				
7.				

Are services related to a workers' compensation or motor vehicle accident claim? ☐ Yes ☐ No

Is anyone in your household: (Check all that apply)

☐ Pregnant Who? _____

☐ A victim of a crime that caused injury Who? _____

☐ Disabled Who? _____

☐ Not a U.S. citizen Who? _____

If LPR how many years? _____ Immigration status: _____

☐ Eligible for COBRA insurance Who? _____

Do you have or plan to file a personal injury claim to compensate for injuries received? ☐ Yes ☐ No

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

Do you receive subsidized Housing, Food Stamps or Women's Infants and Children's Program (WIC) ☐Yes ☐No

Monthly Household Income Information:

	Patient	Spouse/Co-Applicant
Gross Income (before deductions)		
Self Employment Income		
Unemployment		
Social Security/SSI (please specify):		
Retirement (Pension, Annuity)		
Alimony or Child Support		
Interest and Dividends from Investment Accounts		
Real Estate Rental Income		
Other Income		
Total Income		

Total Household Income

Monthly Household Expense Information:

	Total		Total
Mortgage/Rent		Groceries	
Electricity		Car Payment (s)	
Household Gas		Day Care	
Water/Sewer		Child Support/Alimony	
Phone/Cell Phone		Student Loans	
Cable/Internet		Medical Expenses	

Total Household Expense

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

INFORMATION OBTAINED FROM: _____ RELATIONSHIP TO PATIENT: _____

I would like to apply for financial assistance with McPherson Hospital, Inc. I understand that it is the expectation of McPherson Hospital that patients use all of their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this Application and supporting documents are true and complete. By signing this form, I agree to allow McPherson Hospital to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to McPherson Hospital for this same purpose. I understand that McPherson Hospital may require more specific proof of any information on this FAA and supporting documents will be provided upon request. If any information in this FAA and supporting documents is found to be false, misleading, or incomplete, my application for assistance will be denied. McPherson Hospital reserves the right to re-evaluate and/or reverse any charitable service designation if material information is not disclosed, or information was misrepresented or deliberately withheld, or if I (or my heirs) make demand for or file a civil action against a third party for personal injuries or damages (including medical charges/expenses). I understand and agree that any financial assistance granted by McPherson Hospital may not be used by me or my legal representatives in any negotiations, settlements or lawsuit for the purpose of enhancing an award of monetary damages. Should this occur, I agree that McPherson Hospital has the right to reverse any charitable service designation and pursue full charges. The undersigned agrees that the hospital may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

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_____ _____

Applicant's Signature Date Co-Applicant's Signature Date