NCH Norton County Hospital

Financial Assistance Application

In our mission to serve the healthcare needs of residents of Norton County and surrounding area, Norton County Hospital (NCH) is committed to making care affordable. NCH offers discounts on prompt payment at time of service, payment plan options and financial assistance to people who cannot afford to pay for medical care, including Emergency Department, inpatient and outpatient services. NCH offers medically necessary services in our facility at a discounted rate or free of charge if you are an eligible candidate under the Financial Assistance Program (FAP).

The financial assistance program applies to all medically necessary hospital inpatient, outpatient and Emergency Department services that are billed by NCH. Excluded from this program are copays, deductibles or coinsurance as calculated by individual insurance plans. The applicant must demonstrate an inability to pay in accordance with the income criteria as established by the current Federal Poverty Guidelines (FPG).

The Financial Assistance policy and procedure is available on request from the NCH Business Office or available on the NCH website.

Application Instructions: **All questions must be answered. If a question does not pertain, write N/A on the line. Approval of application is contingent on proof of income with application and Medicaid denial letter.**

Income documentation required: Include one of the highlighted items and any other proofs of income with this completed application.

1. **Last year's tax return statement OR Social Security summary/award letter**
   AND any of the following that apply
2. **Last 2 paycheck stubs for current year-to-date income**
3. **Unemployment and/or Food Stamp summary**
4. **Letter from employer – on letterhead (to include employee name, hourly wage, number of hours worked)**
5. **Bank statement showing direct deposit of child support**
6. **Self-employed/farmer – balance sheet/statement of assets and liabilities.**

DATE RECEIVED COMPLETED: ____________________

ADDITIONAL INFORMATION REQUESTED: _____________ INTERVIEW DONE: ____________________ Admin initials: ____________

NCH Norton County Hospital

Financial Assistance Application

Date of Application ______________________

Account No. or Social Security No and Date of Birth ______________________

Applicants Name ______________________

Employer ______________________

Street Address ______________________

Spouse ______________________

City, St, Zip ______________________

Spouse Employer ______________________

Phone Number ______________________

Email address ______________________

Citizenship (check one): ☐ U.S. Citizen ☐ Non-US Citizen ☐ Legally Documented Resident

Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow/er

Names of Dependents (legal deductions on your tax return, not self or spouse) Number in household ____________

Name: ______________________ Relationship: ______________________ Date of Birth: ____________
Name: ______________________ Relationship: ______________________ Date of Birth: ____________
Name: ______________________ Relationship: ______________________ Date of Birth: ____________

Have you applied for Kansas Medicaid for yourself or your dependents? ☐ Yes ☐ No

Do you have commercial insurance or Medicare for yourself or your dependents? ☐ Yes ☐ No

Bank Accounts/Other Assets **(must answer all three questions)**

Checking Account? ☐ Yes ☐ No $____________________

Savings Account? ☐ Yes ☐ No $____________________

Additional Assets? ☐ Yes ☐ No Describe ______________________________________

Income

Income/Social Security:	$	/per month	Food Stamps	$	/per month
Pension/Retirement	$	/per month	Child Support	$	/per month
Unemployment:	$	/per month	Other Income/SSI	$	/per month
	$	/per month	Survivors Benefit/SSI	$	/per month
			TOTAL INCOME:	**$**	**/per month**

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third party payment or liability. Norton County Hospital retains its rights to recover the full balance of my bill from any third party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to Norton County Hospital to obtain information from any source to verify the statements I (we) have made.

______________________________________ ______________________

Patient / Guarantor Signature Date

Updated – 7/14/2021
Norton County Hospital Financial Assistance Application

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