



Washington County Hospital

304 East 3rd Street - Washington, KS 66968 - Phone (785) 325-2211 - Fax (785) 325-3224

Application for Patient Financial Assistance

1. Please provide the following information for all adults in your household (including unmarried partners).		
	Applicant (Patient/Guarantor)	Spouse/Partner
Name		
Street Address		
City, State, Zip		
Home Phone Number		
Other Phone Number		
Social Security Number		
Date of Birth		
Employer		
Employer Address		
Length of Employment		
If Unemployed, Last Day of Employment		

2. Please list any dependent children living in your household (Attach a separate list if more than 6).		
Name	Date of Birth	Relationship

3. Please list the date and reason for hospitalization or service.

4. Please list amounts you owe other medical providers and attach proof.

5. Do you or members of your household have assets to pay for your care?

- a. If you or members of your household have **more than 2 months normal living expenses** on hand, in any of the following forms, please mark the items and attach full documentation to this application.

☐ Checking Accounts ☐ Savings Accounts ☐ Trust Funds
☐ Investment Accounts ☐ Second Home ☐ Boats
☐ Recreational Vehicles ☐ Other Luxury Items OR

- b. My household does NOT have assets of this type exceeding two months' normal living expenses on hand. _____ (Initial)

6. Please attach copies of the following items (for all members of the household) with this application. If you are unable to provide any of the items, please explain why. ***Please do not send original documents as they may not be returned.***

- a. Copy of all checking and savings account statements for the last three (3) months.
- b. Copy of your most recent Federal Tax Return. If unable to provide most recent Federal Tax Return, provide **ALL** W2s, 1099s, or other income for all adults within the household.
- c. Previous 3 months pay stubs and/or previous 3 months of income and expenses if either spouse is self-employed. Verification of unemployment benefits payments or exhaustion of benefits. If married, proof of income is required for both spouses.
- d. Copy of your denial notice from your KanCare (Medicaid) application for medical assistance.

7. Additional Comments:

8. I certify that all the information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services at Washington County Hospital. I hereby grant permission to Washington County Hospital to investigate the information therein. I voluntarily submit this application for financial assistance for my medical bills.

Applicant Signature _____ **Date**

Spouse/Partner Signature _____ **Date**

Please return or mail your application and documentation to the WCH Business Office at the address below. The Business Office is open 7:00 a.m. to 5:00 p.m., Monday through Friday; applications are accepted in person between 8:00 a.m. and 4:30 p.m.

Washington County Hospital
Attn: Heather Laflen – Business Office
304 East 3rd Street
Washington, KS 66968

Questions? Contact Heather Laflen at 785-325-2211 ext. 6210 or directly at 785-510-6210.

OFFICE USE ONLY

Date Application Received: _____

Date Application Approved: _____ **Declined:** _____

Notes: