



Washington County Hospital

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

Financial Assistance Application

Washington County Hospital's Financial Assistance Program has been established to provide financial relief to those who are unable to meet the financial obligations incurred for health care at WCH. As always, confidentiality will be maintained throughout the entire process. **Emergency care will always be given regardless of your ability to pay.**

To be considered for financial assistance, the patient's account balance must be \$1,500.00 or more. Individuals meeting that requirement will be evaluated for financial assistance eligibility under this policy *unless one of the following criteria applies:*

1. Patients who are not a Washington County Hospital service area resident.
2. Patients who are referred to the Hospital Assistance Program and refuse to cooperate and seek alternative resources for payment.
3. Patients who refuse to cooperate with their insurance carrier or did not provide insurance information until after timely filing requirements had expired.
4. Patients who received payment directly from their insurance carrier, but refused to apply the insurance payment to their account.
5. Patients with a court-ordered judgment to satisfy their account balance.
6. Patients who had services as a result of their own illegal activity.

Enclosed is an Application for Patient Financial Assistance. If you choose to complete the application and return it to the hospital, you could be eligible for a reduction of your self-pay balance for medically necessary inpatient, outpatient and emergency services at WCH.

Please provide the following to WCH:

1. A copy of all checking and savings account statements for the last three (3) months.
2. A copy of your most recent Federal Tax Return. If unable to provide a most recent Federal Tax Return, provide **ALL** W2s, 1099s, or other income for all adults within the household.
3. A copy of the previous three (3) months' pay stubs and/or previous three (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.
4. A copy of your current Medicaid (KanCare) denial letter. KanCare is the State of Kansas Medicaid program; information and applications are available at www.kancare.ks.gov. You may also apply through the local DCF office located at 406 North 3rd Street, Suite 2, Marysville, KS, or call 785-562-5338 to request an application.
5. Please make sure you sign and date the attached application. If applicable, spouse and/or partner must also sign and date.
6. Please complete the application in full or provide reasoning as to why it is not complete.
7. Please return the application and attached information within 30 days of receipt unless otherwise informed. The application may be mailed to our address at the top of this page or hand delivered to the WCH Business Office. 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.

Failure to return the above items with your application in a timely manner may result in denial of your request for Patient Financial Assistance.

If you have any questions or need any assistance in completing this application, please contact Heather Laflen at 785-325-2211 ext. 6210 or directly at 785-510-6210.