



Hospital District #6 Harper County
485 N KS HWY 2, Anthony, KS 67003
620.914.1200
pattersonhc.org

Uncompensated Care Application

The attached information is necessary for us to reach a decision regarding your account(s). Failure to supply requested information could hinder processing and may result in your account(s) being sent to collections. Information received will be regarded as confidential and used only for determining financial status.

Please include the following information with your application to aid us in determining your financial status:

1. Present source of income (copy of last four paycheck stubs) or statement from employer verifying wages.
2. IRS W-2 issued during the past year or most recently filed IRS Tax Form (for example, 1040, 1040EZ).
3. Last two months entire bank statements for checking, savings, money market, and investment accounts.
4. Written Statements for the most recent two months for all other income (Unemployment Compensation, disability, retirement, in-kind assistance etc.)
5. Unemployment Denial Letter, if applicable.
6. Contribution statements from individuals who contribute income or in-kind assistance to the patient.

Please return application to the Patterson Health Center business office. If you have questions or concerns, please contact the business office at Patterson Health Center at (620) 914-1200 ext. 5011

I hereby request that Hospital District No. 6 of Harper County, KS make a written determination of my eligibility for financial assistance. I certify that all information is true and correct to the best of my knowledge. I understand that the information given will be used to ascertain my ability to pay for services provided by Hospital District No. 6 of Harper County, KS Patterson Health Center and any associated clinics. I grant permission for Hospital District No. 6 of Harper County, KS to verify the information provided herein and authorize my employer/institution to release such information.

Signature _____

Date _____

Section I – Contact Information

Patient Name _____

Guarantor Name _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Employer _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Spouse Name _____

Spouse Employer _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Section II – Monthly Income

Source

Amount

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Total Monthly Income

Section III – Monthly Expense

Expense Item	Bank/Company	Balance	Monthly Payment
Home Mortgage	_____	_____	_____
Vehicle Loan #1	_____	_____	_____
Vehicle Loan #2	_____	_____	_____
Credit Card #1	_____	_____	_____
Credit Card #2	_____	_____	_____
Medical Bills	_____	_____	_____
	_____	_____	_____
Other Loan(s)	_____	_____	_____
Rent Payment	_____	_____	_____
Auto Insurance #1	_____	_____	_____
Auto Insurance #2	_____	_____	_____
Utilities (Electric)	_____	_____	_____
Utilities (Gas)	_____	_____	_____
Telephone	_____	_____	_____
Cell Phone	_____	_____	_____
Cable/Satellite TV	_____	_____	_____
Internet Service	_____	_____	_____
Groceries	_____	_____	_____
Child Care	_____	_____	_____
Auto Fuel	_____	_____	_____
Life Insurance	_____	_____	_____
Other	_____	_____	_____

Total Monthly Expenses			_____

Section IV – Summary

Total Monthly Income	_____
Total Monthly Expense	_____
Income Less Expense	_____

For Hospital/Clinic Use Only

SEE ATTACHED PRINTOUT FOR ITEMIZATION OF ACCOUNTS.

Date application received by hospital/clinic _____

Received by: _____ Date: _____

Amount of payment Approved:

Hospital \$ _____

Clinic \$ _____

Reason for Denial _____

Date of approval or denial by CFO _____

Date of approval or denial by Finance Committee _____

Chief Executive Officer