Patterson Health Center
485 N KS HWY 2
Anthony, KS 67003
620.914.1200
pattersonhc.org

UNCOMPENSATED CARE PROGRAM

Patterson Health Center is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance. Below you will find an application that demonstrates your financial situation. **You must complete this document in full to receive consideration for our financial assistance program.** If your financial situation meets the criteria set forth by Patterson Health Center, part or all your account balance may be forgiven. Information received will be regarded as confidential and used only for determining financial status.

In addition to a completed application please provide the following:

- Copy of your most recent Federal 1040 tax return, including all applicable schedules.

And one of the following:

- Copy of last two pay stubs for any wage earner contributing to household income
- Social Security Awards Letter or most recent 1099 if receiving Social Security (If you are receiving Social Security as well as have other income, please provide proof of additional income)

If you have questions or concerns, please contact the business office at (620) 914-1200 option 1.

I hereby certify that all information and supporting documentation is true and correct to the best of my knowledge. I understand that the information provided will be used to ascertain my ability to pay for services provided by Patterson Health Center. I grant permission for Patterson Health Center to verify the information provided herein. Patterson Health Center has made no representations that financial assistance is guaranteed.

Name(Print)_____Signature_____Date_____

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UNCOMPENSATED CARE APPLICATION

Demographics

Name:_____ Date of Birth:_____

Spouse Name:_____ Date of Birth:_____

Address_____ City:_____ State:_____ Zip Code:_____

Cell Phone :_____ Cell Phone (Spouse)_____

Please list all additional people living in your household:

Name:_____ Date of Birth:_____ Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____ Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____ Name:_____ Date of Birth:_____

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Income to Report

Earnings from Work Wages/salaries/tips Unemployment compensation Workman's compensation Net income from self-owned business or farm	**Pensions/Retirement/Social Security** Pensions Retirement income Social Security Veteran payments Supplemental Social Security
Welfare/Child Support Alimony Public assistance payments Welfare payments Alimony payments Child support payments	**Other Income** Earnings from second job Disability benefits Rental Income Interest/Dividends Income from Estates/Trusts/Investments Regular contributions from persons not living in the household

Gross household income must be accurately stated for everyone that lives in the household. Gross income is your income before any taxes or deductions of any type are taken out of your wages. Types of income that are listed above must be reported.

What is the household's gross income per month? _____

If no income is listed, please explain how your needs of shelter, food, clothing, etc. are met.

_____
_____
_____
_____
_____
_____

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In the following space, PLEASE WRITE AN EXPLANATION OF YOUR CURRENT FINANCIAL SITUATION. If you do not have enough space, please write additional information on back of this sheet.

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For Internal Office Use Only:

Date application received by Patterson Health Center_____

Account Balances eligible for Uncompensated Care:

Hospital_____

Clinic_____

Total_____

Discount % approved:_____

Discount amount approved:_____

CEO Signature:_____ Date:_____

If account balance $2,000 or more:

Finance Committee Signature_____ Date:_____

Updated 11-14-24 - LA