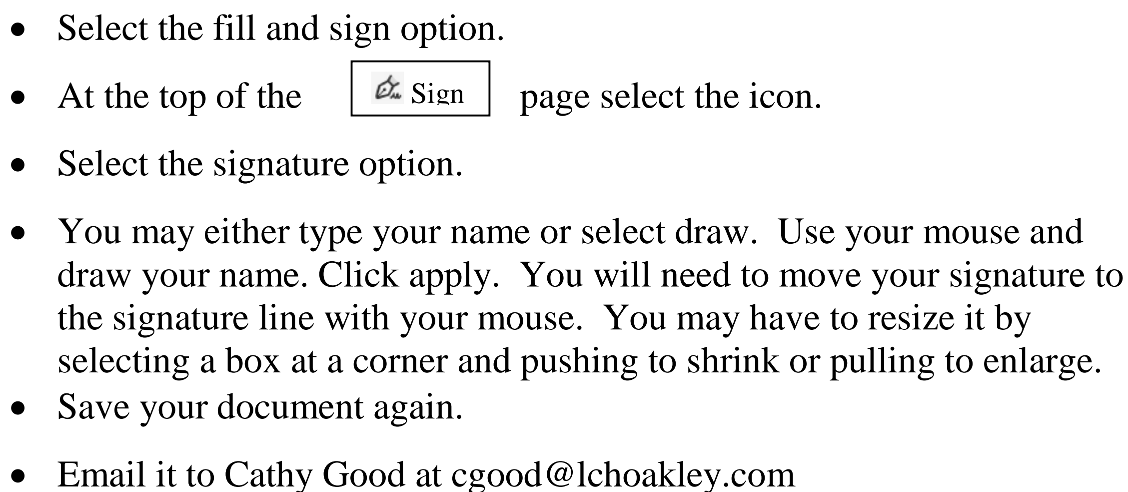
Directions for complete this form online for emailing or printing.

Windows/Macintosh computers

Download form and open in Adobe Reader DC. The blanks of the form are fillable, just click and type. Make sure you save often. Once you have completed the form save again. To complete the signature part of the form you may do one of the following:

- Type your signature for emailing
- Click on the fill and sign option
- You may print the form and manually sign.

If you clicked on the fill and sign option follow these steps.



- Select the fill and sign option.
- At the top of the [Sign] page select the icon.
- Select the signature option.
- You may either type your name or select draw. Use your mouse and draw your name. Click apply. You will need to move your signature to the signature line with your mouse. You may have to resize it by selecting a box at a corner and pushing to shrink or pulling to enlarge.
- Save your document again.
- Email it to Cathy Good at cgood@lchoakley.com

Android/iPhone

The easiest way to complete this form is to download the free app AdobeFill&Sign.

- Download the pdf file.
- When the options appear select Copy to AdobeFill&Sign.
- Click the line you need to complete and type.
- To sign the document select the signature line and touch the pen at the bottom of the window. Write your name.

Email it to Cathy Good at cgood@lchoakley.com

LOGAN COUNTY HOSPITAL
NEW FRONTIERS HEALTH SERVICES

FINANCIAL ASSISTANCE APPLICATION

1. APPLICANT: ______________________________ CO-APPLICANT: ______________________________

ADDRESS:____

TELEPHONE: (_____)______________________ SSN#: ______________________________

OCCUPATION: ____________________________ CO-APPLICANT: ____________________

EMPLOYER: ________________________ SPOUSE EMPLOYER: _________________________

TELEPHONE#_________________________ TELEPHONE#_________________________

2. INCOME: List gross income for Family for the last 12 months:

Wages* ______________________
Farm or Self-Employment ______________________
Social Security ______________________
Unemployment Compensation ______________________
Worker's Compensation ______________________
Pension ______________________
Other Income ______________________

*Please provide signed copies of the last two (2) years Federal and State Income Tax Returns and most current 90 days of pay stubs for all wage earners in the household.

3. FAMILY SIZE:________________

Name Relationship

____

____

____

____

____

I affirm the information I have provided above is true and accurate and subject to verification:

_______________________________________ ______________________________

Signature of Applicant Date of Request

*Return this application to Logan County Hospital, 211 Cherry, Oakley, KS 67748.

Office Use Only

Date Application Sent: _______________________ By: __________________________

Date Application Received:_____________________ By: __________________________