


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  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
PAYMENT PLAN 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	_____
Dividends, Interest, Rent, etc.	_____
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.

FAMILY SIZE: _____

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

3. EXPENSES: List all monthly expenses to be considered in creating monthly payment.

Rent/Mortgage	_____
Utilities: Heat/Electricity/Water	_____
Vehicle Expense	_____
Child Care	_____
Insurance	_____
Food	_____
Medical	_____
Other _____	_____

List all other expenses on the back side of this page.

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.

Other Expenses:

Office Use Only

Date Application Sent: _____

By: _____

Date Application Received: _____

By: _____

Date Application Approved: _____

By: _____