Logan County Hospital
211 Cherry
Oakley, Ks 67748

New Frontiers Health Services
212 Maple
Oakley, Ks 67748

FINANCIAL ASSISTANCE APPLICATION

In our mission to serve the healthcare needs of residents of Northwest Kansas, Logan County Health Services is committed to making care affordable. We offer discounts, payment options, and financial assistance to people who cannot afford to pay for medical care, including Emergency Department services. Logan County Hospital and New Frontiers Health Services offer medically necessary services at a discounted rate to eligible candidates under the Financial Assistance Program (FAP). The Financial Assistance policy and procedure is available upon request by calling 785-672-9156.

Instructions: All questions must be answered. If a question does not pertain to you, please write N/A.
Return completed application with requested supporting documents to Danel Younkin, Financial Advisor by mail or email: dyounkin@lchoakley.com

Patient or Parent/Guardian Information

Name: ____ DOB: _____ / ______ / ______

Street Address: ____ City: _____________________

State: _________ Zip: __________ Phone Number: ( ) _________________ SSN: _______-_____-___________

Email Address: _______________________________ Marital Status: ___________________

Household Size (including applicant): ________ US Citizen or Permanent Resident ☐ Y ☐ N

Employment Status:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Employer Name and Address: ____

If unemployed, please provide dates of unemployment period: From___________To___________

If you rely on student loans to pay for basic living expenses, please provide copies of student loan and allocations.

How often are you paid: ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Semi-monthly

Gross Monthly Salary: ________________________ From: ________________ To: ______________________

Are you claimed on someone else's taxes as a dependent: ☐ Y ☐ N

Insurance Information

Is the applicant covered by health insurance? ☐ Y ☐ N

Has the applicant applied for Medicaid benefits within the last 3 months? ☐ Y ☐ N

Is the applicant pregnant, under the age of 19, a caretaker of a child, over the age of 65, or disabled? ☐ Y ☐ N

If the patient has been denied Medicaid within the last 3 months, please attach a copy of the denial notice.

Does the patient have a lawsuit, settlement, personal injury, work comp, or liability claim pending? ☐ Y ☐ N

Do you feel you are unable to receive necessary medical care because of the financial burden it may cause? ☐ Y ☐ N

Spouse Information

Name: ____ DOB: _____ / ______ / ______

SSN: _______-_____-________ Phone Number: ( ) ________________ Email:________________________

Employment Status:

☐ Full Time ☐ Part Time ☐ Self Employed ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

If unemployed, please provide dates of unemployment period: From__________To__________

Dependent Information: Approval requires proof of most recent tax return (use separate page if more than 6)

Full Name	DOB	Relationship	Claimed on taxes?		Covered by Insurance?	
____________________	___/___/____	_______________	Y	N	Y	N
____________________	___/___/____	_______________	Y	N	Y	N
____________________	___/___/____	_______________	Y	N	Y	N
____________________	___/___/____	_______________	Y	N	Y	N
____________________	___/___/____	_______________	Y	N	Y	N
____________________	___/___/____	_______________	Y	N	Y	N

Gross Monthly Income for ALL household members: Approval requires proof of the last 2 months income documents

Employment Wages:	$______________________	Workers Comp:	$______________________
Pension/Retirement:	$______________________	Child Support:	$______________________
Rental Income:	$______________________	Alimony:	$______________________
Short/Long Term Disability:	$______________________	SSI/SSDI Social Security:	$______________________
Unemployment:	$______________________	Misc:	$______________________

Asset Information: Approval requires proof of all assets for the last two months, i.e. last 2 bank statements

Checking Balance: $____________________ Savings Balance: $__________________ CD: $_____________

Stocks/Bonds: $____________________ $401K: $_________________________ Other: $_______________

To help us better understand your needs, please describe your current financial situation and why you are unable to pay your balance or make monthly payments. Please be specific (use separate sheet if needed).

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Did You Remember to Attach:

☐ 2 months income proof ☐ 2 months bank statements ☐ most recent tax return ☐ Medicaid denial

I hereby declare that the above information is true and correct. If the information supplied is inaccurate or incomplete, or the patient's family income exceeds the charity guidelines, I understand that I will be responsible for payment of the entire balance of the bill. I understand this determination is conditional and does not apply to third party claims such as lawsuits, settlements, hospital liens, or any other third-party payment or liability. LCHS retains its rights to recover the full balance of my bill from any third-party resource to the fullest extent allowed by law. If my (our) case is selected for Indigent Care classification, I (we) give my (our) consent to LCHS to obtain information from any source to verify the statements I (we) have made.

Parent/Guarantor Signature: ____ Date: ____________________

Administrative Signature: _______________________________ Date: ____________________