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
211 Cherry
Oakley, KS 67748

New Frontiers Health Services
212 Maple
Oakley, KS 67748

Personal Financial Statement for Financial Assistance/Payment Plan

Patient Name:	DOB	Phone Number _____-_____-_____	Marital Status S M W D	Social Security Number _____ - _____ - _____

Date Pt. Received/Sent:	**Acct #:**	**Balance:$**
Please Return By:	**Acct #:**	**Balance:$**
Date Returned:	**Acct #:**	**Balance:$**

Patient	Person Responsible for Bill (if not patient)	Relationship
Street:	**Name:**	
City, ST, Zip	**City, ST, Zip**	
Phone: ____-____-_____ Cell: ____-____-_____	**Phone: ____-____-_____ Cell: ____-_____-_____**	

EMPLOYMENT

Patient's Employer:	**Guarantor's Employer:**
Occupation:	**Occupation:**
If unemployed, Name of Last Employer:	**If unemployed, Name of Last Employer:**
How Long Unemployed?	**How Long Unemployed?**

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	DOB	Relationship to Patient

Do you have health insurance coverage available? Yes☐ No☐

If yes, why not available for this date of service? _____

If no, please indicate the reason or lack of insurance coverage. Insurance cost too high? Yes☐ No☐

Pre-existing condition? Yes☐ No☐ Other, please describe _____

Have you applied for Medicaid? Yes☐ No☐ Date applied: _____

If denied, date: _____ Reason for denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income: Last year's Income Tax Return & last 3 months paycheck stubs				
	Patient	**Spouse/Other**	**Other Members of Household (18 and older)**	
Wages (Gross)	$	$		
Social Security				
Pensions				
Unemployment/Work Comp				
Government Assistance				
Disability Payments				
Dividends/Interest				
Other, List				
MONTHLY INCOME				
TOTAL INCOME:	**MONTHLY: $**		**YEARLY:**	

EXPENSES	**MONTHLY**	**BALANCE DUE**	**HOUSEHOLD ASSETS**	**VALUE**
Mortgage or Rent Payment	$	$	Savings	$
Car Payment			Checking	
Utilities (Gas, Electric, Water			Stocks and Bonds	
Cable			Mutual Funds, Money Marekt, etc.	
Phone (Including Cell)			Cash Value of Life Insurance	
Food			Real Estate Value	
Child Care			Farming Real Estate Value	
Clothing			Vehicles Value (not primary)	
Insurance (Auto, Life, Health)			Jewelry & Other Personal Property	
Gas/Transportation			Other Assets (Describe)	
Recreation				
Physicians				
Hospitals				
Other Medical				
Credit Cards				
Other Expenses (Describe)				
			TOTAL HOUSEHOLD ASSETS:	**$**
			HOUSEHOLD DEBTS	**VALUE**
			Home Loan	$
			Auto Loan	
			Credit Card Debt	
			Other: Total Expenses from "Balance Due"	
			column - (Mortgage + Car Loan + Cr, Cards)	
TOTAL EXPENSES:	**$**	**$**	**TOTAL HOUSEHOLD DEBTS:**	**$**

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date:

Application Determination: Approved / Denied Date Determination Letter Mailed:

Reason for denial: _____

Hospital Representative Signature (s) Date: