Edwards County Hospital & Healthcare Center

Financial Assistance Application

DIRECTIONS:

Answer each question
Use N/A if non-applicable

PLEASE PROVIDE COPIES OF THE FOLLOWING:

Wage/Income statements for the past 90 days (pay stubs)
Complete previous year's tax return
Copy of insurance/Medicaid denial notices

If you have any questions regarding the Financial Assistance Application, please call:
ECH Business Office at (620) 659-3621.

1. PATIENT INFORMATION

Patient Name: ____

Spouse's Name:____

Address: ____

City, State & Zip Code ____

Phone Number __________________________Number of Dependents: _________________________

2. HOUSEHOLD INCOME

Total wages of Patient: ___________________________

Employer Name: ____

Employer Address: ____

City, State & Zip Code: ____

Total wages of Spouse: ___________________________

Spouse's Employer: ______________________________

Spouse's Employer Address: ____

City, State & Zip Code: ____

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3. OTHER INCOME

Disability Payments: ________________________

Alimony/Child Support: ______________________

Retirement Benefits: ________________________

Investment Income: _________________________

Social Security: _____________________________

Other: ____________________________________

4. TOTAL MONTHLY INCOME $____

5. HOUSEHOLD ASSETS

A. Real Property

Address: ____

City, State & Zip Code ____

Rent: _____________________________ Own: ____________________________________

Market Value: ____________________________

Mortgage Balance: ________________________

Net Value Property: _______________________

Mortgage Bank: ___________________________

Mortgage Bank Address: ____

____

B. Automobile

Make: ____

Model: ____

Year: ____

Loan Balance: ____

Net Value: ____

C. Other Assets

Savings Account Number: ____

Balance: $____________________

Checking Account Number: ____

Balance: $____________________

Certificate of Deposit Bank Name: ____

Balance $____________________

Insurance Cash Value: ____

Stocks, bonds, Other: ____

Source: ____

Cash Value: $______________________

All of the information provided in this Financial Assistance Application is true and complete and may be verified with the listed institutions by Edwards County Hospital & Healthcare Center. I consent to the release of all my personal account balance information to Edwards County Hospital & Healthcare Center for verification.

Date: _____________________ Signature of Patient ________________________________

Date: _____________________ CEO ____

Please return completed application within fifteen (15) days to:
Edwards County Hospital
Attn: Business Office
P.O. Box 99
620 W. 8th. St.
Kinsley, KS 67547

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