# 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: $_____

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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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