Financial Assistance Application
Geary Community Hospital

Is this application for past services? YES _____ NO _____ Past Dates of Service _____

Where were/are services being performed? _____

Patient's Information:

_____

Last Name First Name Middle Initial Social Security Number Date of Birth

Street Address City State Zip Code

Mailing Address City State Zip Code

Please circle one: Single Married Common Law Separated Divorced Widowed

Gender: Male _____ Female _____ Language: English _____ Spanish _____ Other _____

Home Phone Number: _____ Work Phone Number: _____

Person Responsible for paying the bill:

Last Name First Name Middle Initial Social Security Number Date of Birth

Name of the Insurance Company (VA, Medicare, Commercial, etc.) Effective Date

Please indicate ALL people living in the household, including applicant. Indicate who you are claiming on your tax return:

(Use an additional sheet of paper if needed)

SELF

Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent
Name	Relationship to Patient	Social Security Number	Date of Birth	Tax Dependent

Are services related to a workers' compensation or motor vehicle accident claim? YES _____ NO _____

Is anyone in your household: (Check all that apply)

Pregnant	**Who?**
A victim of a crime that caused injury?	**Who?**
Disabled?	**Who?**
Not a U.S citizen: **If LPR how many years? _____**	**Who?** **Immigration status: _____**
Eligible for COBRA insurance?	**Who?**
Do you have or plan to file a personal injury claim to compensate for injuries received?	**YES _____ NO _____**

Do you receive subsidized Housing, Food Stamps or Woman's infants and Children's Program (WIC)?

YES _____ NO _____

Monthly Household Income Information	**Patient**	**Spouse/ Co-Applicant**
Gross Income (before deductions)		
Self-Employment Income		
Unemployment		
Social Security/SSI (please specify)		
Retirement or Child Support		
Alimony or Child Support		
Interest and dividends from investment accounts		
Real Estate Rental Income		
Other Income		
Total Income		

Total Household Income _____

Monthly Household Expense Information:

	Total		Total
Mortgage/Rent		**Groceries**	
Electricity		**Car Payment (s)**	
Household Gas		**Day Care**	
Water/Sewer		**Child Support/Alimony**	
Phone/Cell Phone		**Student Loans**	
Cable/Internet		**Medical Expenses**	

Total Household Expense | |

If you have no monthly income, please attach an explanation of how you are meeting your monthly living expenses.

INFORMATION OBTAINED FROM: _____

RELATIONSHIP TO PATIENT: _____

I am applying for financial assistance with Geary community Hospital (GCH) as billing/collection agent for the affiliated healthcare providers indicated above. I understand that it is the expectation of GCH that patients use all their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this application and supporting documents are true and complete. By signing this form, I agree to allow GCH to verify my employment and credit history for the purpose of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to GCH for this same purpose. I understand that GCH may require more specific proof of any information on this financial assistance application (FAA) and supporting documents will be provided upon request. If any information in this FAA and supporting documents if found to be false, misleading, or incomplete, my application for assistance will be denied. GCH reserves the right to re-evaluate and/or reverse any charitable services designation if material information is not disclosed, or information was misrepresented or deliberately withheld.

APPLICANT SIGNATURE:_____DATE:_____

WHAT DOES THIS MEAN?

Internal Use (only)

A Guide to Assist in Completing the GCH Financial Assistance Application

GUARANTOR	This is the person who is responsible for paying the bill for healthcare services at Geary Community Hospital (GCH). This could be the patient, the parent of a child or someone who is claiming responsibility for an outstanding bill.
DEPENDENTS	Dependents are any individual who can be considered a dependent on an IRS income tax form. A dependent includes the patient, a spouse, a child, etc.
CURRENT ADDRESS	We need to know your current address so we can send a written response to you once your application has been processed. To qualify for GCH financial assistance, this address must be located in Geary County (including Fort Riley) or your primary care provider is a GCH provider.
PROOF OF CURRENT RESIDENCE	Proof of your current residence will be required and may include: address listed on tax forms, paycheck stubs, disability letter and/or a utility bill.
PRIMARY CARE PROVIDER	A doctor, usually a family or general practitioner, internist or pediatrician, who is chosen by an individual to provide or coordinate that entire person's health care needs. A specialist, consultant or surgeon is **not** considered a primary care provider. If you do not currently live in Geary County, your primary care provider must be on the Geary Community Hospital medical staff.
MEDICAL BENEFITS	The GCH Financial Assistance program is a last resort program when all avenues to attempt to find coverage and/or payment for services have been exhausted. If you or your family has not completed a screening for possible medical coverage, your application could be denied.
IRS 4506 Form	For individuals who have not worked during the past year and did not file a tax return, you will be asked to sign a 4506-T IRS form to request any transcripts from the IRS to document your financial status.
FINANCIAL DISCOUNTS DEFINED	FINANCIAL ASSISTANCE: 100% discount (0%-125% Federal guidelines) SLIDING SCALE DISCOUNT: 50% discount (Income 151%-175% of Poverty Guideline) 25% discount (Income 176%-200% of Poverty Guideline) The Federal poverty guideline used for determining financial assistance is provided in the table below:

2018 Federal Poverty Guidelines

Household/ Family Size	100%	125%	150%	175%	200%
1	$12,140	15,175	18,210	21,245	24,280
2	$16,460	20,575	24,690	28,805	32,920
3	$20,780	25,975	31,170	36,365	41,560
4	$25,100	31,375	37,650	43,925	50,200
5	$29,420	36,775	44,130	51,485	58,840
6	$33,740	42,175	50,610	59,045	67,480
7	$38,060	47,575	57,090	66,605	76,120
8	$42,380	52,975	63,570	74,165	84,760

For families/households with more than 8 persons, add $4,970 for each additional person.