GEARY COMMUNITY HOSPITAL FINANCIAL ASSISTANCE APPLICATION

Please complete all the requested information. Please use the "What Does This Mean?" tool located on the back of this application for help in completing this form. Any false information could lead to automatic denial of this application.

Guarantor: _____ Date of Birth: _____

Dependents: _____ _____

_____ _____

Current Address*: _____ Daytime Telephone Number (___) _____

_____

*Proof of residence will be required with this application

If your current residence is not located in Geary County, please provide your Primary Care Provider on the line below. Otherwise, you may leave blank.

Primary Care Provider: _____

Have you talked to someone recently about whether you may qualify for medical benefits such as Medicaid, MediKan, Crime Victims, SOBRA, etc.? _____ Yes _____ No

If you have not been recently screened for medical benefits, this application may be denied. Please contact 1-877-803-6675 and request a financial screening. If you elect to be screened by another agency, please provide proof with this application that you have been denied access to other medical benefits.

Income Information*: Wages: $_____ per week/month/year {Circle the time frame that applies}

Disability: $_____ per week/month approved for _____ months

Child Support: $_____ per week/month/year {Circle the time frame that applies}

Unemployment: $_____ Other Income: $_____

* Please provide proof of income for the past 12 months.

Additional Comments: _____

_____

_____

_____
Signature

_____
Date

Checklist of additional documents to include with completed application:

□ Proof of residence

□ Medical benefit screening information (if applicable)

□ Proof of income (for past 12-months)

□ Signed and dated application

FINANCIAL ASSISTANCE APPLICATION
WHAT DOES THIS MEAN?
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.
INCOME	GCH requires at least 12-month's worth of income documentation. This documentation should be complete and demonstrate your current financial situation. Documents may include: Prior year's income tax forms, W-2 forms, pay check stubs showing at least 12-month's worth of income, bank statements, child support forms, disability letters, unemployment letters, etc. 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) LOW INCOME DISCOUNT: 79% discount (126%-150% 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:

2019 Poverty Guidelines

Persons in Household	Poverty Guideline	125% of Poverty Guideline	150% of Poverty Guideline	175% of Poverty Guideline	200% of Poverty Guideline
1	12,490	15,613	18,735	21,858	24,980
2	16,910	21,138	25,365	29,593	33,820
3	21,330	26,663	31,995	37,328	42,660
4	25,750	32,188	38,625	45,063	51,500
5	30,170	37,713	45,255	52,798	60,340
6	34,590	43,238	51,885	60,533	69,180
7	39,010	48,763	58,515	68,268	78,020
8	43,430	54,288	65,145	76,003	86,860

For families/households with more than 8 persons, add $5,530 for each additional person