# FINANCIAL ASSISTANCE APPLICATION FORM

Telephone: (620) 240 - 5682 Fax: (620) 231 - 2808 Email: fa@chcsek.org

Applicant Name (Print):_________________________________ Date of Birth: ____/____/______ Phone Number:______________

Mailing Address: ________________________________________ City: ________________ State: ________ Zip Code: ________

Email Address: _____________________________ Health Insurance: ❑Yes ❑No (If Yes, please list any health insurance your family has.)

❑Medicare, ❑Medicaid/KanCare, ❑Commercial/Private, ❑Other: ______________________________________________________________

Health Insurance Company Name: ___________________________ Health Insurance Company Name: ___________________________

**Family Information:** **Family Size (Including yourself):** ❑1, ❑2, ❑3, ❑4, ❑5, ❑6, ❑7, ❑8, ❑Other: _________

| Name | Date of Birth | Name | Date of Birth |
|---|---|---|---|
| PATENT (If different from applicant) | | DEPENDENT | |
| SPOUSE/PARTNER/DEPENDENT | | DEPENDENT | |
| DEPENDENT | | DEPENDENT | |
| DEPENDENT | | DEPENDENT | |

**Annual Family Income Information (Total income before taxes):**

| Family Member Receiving Income | Type of Income (wages, social security, pension, disability, child support, unemployment, etc.) | How Much | How Often (weekly, monthly) |
|---|---|---|---|
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**Proof of Income:** Please provide income documentation on all family members eighteen (18) years old or older. Proof of income is required to determine financial assistance. If you cannot provide *Proof of Income*, you may fill-out **Income Self-Declaration** on the bottom of the previous page.

**Examples of Proof of Income:** A "W-2" withholding statement; Current pay stubs (3 months); Self-employment information; Last year's income tax return; Pension statements; Supplemental Security Income (SSI) information; Unemployment Benefits statements; Written statements from employers.

**Attestation:** I declare the above information is correct and assume responsibility of contacting CHC/SEK should any changes to financial or insurance status occur. I understand that I will be disqualified from financial assistance for giving false information.

**Patient/Guardian Signature:** ________________________________________ **Date:** ________**(Month)**_________**(Day)**__________**(Year)**

Effective 2/1/14: Revised 8/2012, 5/2013, 7/2013, 3/2014, 7/2014, 3/2015, 12/2015, 3/2016, 3/2017, 4/2017, 7/2017, 2/2019