Community Health Center of Southeast Kansas

Application for
Financial Assistance

Community Health Center of Southeast Kansas provides quality health care to all people, regardless of their ability to pay. This application may provide assistance if you have financial difficulty paying for services.

Steps to receiving Financial Assistance:

- ☑ Fill out application – print clearly.
- ☑ Be sure all supporting documents are attached and the application is signed.
- ☑ Provide proof of address
- ☑ Meet with CHC/SEK representative to review application and determine

Pittsburg
3011 N. Michigan
Pittsburg, KS. 66762
Phone (620) 231-9873
Fax (620) 231-5062

Pittsburg Dental
924 N. Broadway
Pittsburg, KS. 66762
Phone (620) 231-6788
866-396-6788
Fax (620) 231-2331

Baxter Springs
2990 Military Ave.
Baxter Springs, KS. 66713
Phone (620) 856-2900
Fax (620) 856-2901

Coffeyville
801 W 8th St.
Coffeyville, KS. 67337
Phone (620) 251-4300
Fax (620) 251-4979

Columbus
120 W. Pine
Columbus, KS. 66725
Phone (620) 429-2101
Fax (620) 429-2106

Independence
3751 W. Main
Independence, KS. 67301
Phone (620) 577-2131
Fax (620) 577-2134

Iola
1408 East Street
Iola, KS. 66747
Phone (620) 380-6600
Fax (620) 380-6215

Parsons
2100 Commerce Dr.
Parsons, KS. 67357
Phone (620) 717-4450
Fax (620) 717-4540

Financial Assistance Overview

How do I qualify?

To qualify for a discount, you must complete an application and attach proof of income. If you have no income, a self-declaration is required. Please see back page. You must return this application to CHC/SEK for review by a staff member who will determine if you are eligible for a discount.

What benefits do you offer?

Our mission is to provide affordable health care to everyone. To do so, we ask that everyone pay their fair share. A nominal payment will be requested at the time of service. If your monthly income is at or less than the amounts below, you are eligible for a discount.

Family Size	Monthly Gross Income
Family of 1	Less than $2,023
Family of 2	Less than $2,743
Family of 3	Less than $3,463
Family of 4	Less than $4,183

How long will my discount last?

Your discount will be in effect for 12 months. If your income changes during this time, please notify CHC/SEK to be sure you are receiving the proper discount.
When your discount expires, you will need to reapply.

Can I still qualify for a discount even if I have health insurance?

Yes! However, we must file your claim with your insurance first. If the insurance company directly sends you a payment or denial notice, you need to bring or mail it to our office so you can get your discount. Otherwise, you will be billed for the entire amount.

Where can I use my discount?

We can only apply discounts to services provided by CHC/SEK. We cannot discount charges from hospitals, ambulance services or physicians outside of CHC/SEK (even if you have been referred there). Some providers, such as hospitals, do offer financial assistance. Staff will be happy to assist you in identifying and accessing these programs.

Questions? Just give us a call and we will be happy to assist you!

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, 7/2017,4/2018

This box is for office use only

Slide Level: A B C D E	Annual Income: ____________________
Exp. Date: _______________	Scanned Under: _____________________
Approved By: ____________	

Name of Applicant:____Phone number:________________
Address________________________________City, State, Zip____________________________________

List everyone you are financially responsible for including unborn children.

Name	Date of Birth	Relationship to you
1		
2		
3		
4		
5		
6		
7		

Income Information: Please include everyone receiving income. *Income includes, but is not limited to salaries, pensions, social security payments, disability payments, alimony, child support, unemployment, self- employment wages, tips, VA benefits, etc. Discount is calculated on total income before taxes.*

PLEASE ATTACH PROOF OF INCOME.

Name of person receiving income	Type of income	Employer name	How often is this paid?

Health Insurance Information: Please list anyone on this application who currently has insurance.

Name	Type of Insurance

I understand that any insurance payments received by me or on my behalf must be applied to my account before I receive any discounts. I agree to pay my co-pay at the time of service. I certify the above information is correct and assume the responsibility of contacting CHC/SEK should any changes to my financial or insurance status occur. I understand that I will be disqualified for giving false information.

_______________________________________ ___________________________
Signature Date

This Page For Office Use Only

Employment

$______________ Gross Pay

X ______________ # Pay Periods Yearly

$ ______________ **Annual Pay**

Employment

$______________ Gross Pay

X ______________ # Pay Periods Yearly

$ ______________ **Annual Pay**

Social Security/Disability/Retirement

$______________ Gross Pay Before Deductions

X 12 # Pay Periods Yearly

$ ______________ **Annual Pay**

Tax Return

$______________ Line 22 of 1040, line 4 of 1040EZ, or line 15 of 1040A

+______________ Non-Taxable Income

$ ______________ **Annual Pay**

Unemployment

$______________ Maximum Total Benefits

OR

$______________ Weekly Amount

X 26 # Pay Periods Yearly

$ ______________ **Annual Pay**

W-2

$______________ Box 1 of 1st W-2

$______________ Box 1 of 2nd W-2

$ ______________ **Total Annual Pay**

Child Support

$______________ Gross Pay

X ______________ # Pay Periods Yearly

$ ______________ **Annual Pay**

Other

$______________ Gross Pay

X ______________ # Pay Periods Yearly

$ ______________ **Annual Pay**

☐ **Proof of Address for Patient**

ADD ALL ANNUAL PAY TOTALS

$ ______________________

Reviewed By (Print Name/Date):

__________________________ _________

Corrections

Corrections Made: Date: _________

Actions Taken Date: _________

Signature: ______________________________