Application for Financial Assistance
Physicians Group

Parsons, Chanute, Erie, St Paul, Cherryvale, Independence, Independence Women's and Children's, Altamont, Coffeyville, Chetopa, Oswego

Name		Occupation	
Phone		Family Size	
Street	City	State	Zip
Optional Social Security			

Please list all household members' names and date of birth

Please list ALL income for ALL household members for the last 3 months
(Wages/Self-Employment, Public Assistance, Social Security/Disability, Pension, Unemployment, Workers Compensation, Child Support, Rental income, Grants/Scholarships, or any other income)

$
$
$
$
$
$

I (we) authorize the hospital and/or Physicians Group to make whatever inquiries it deems necessary in evaluation of my credit worthiness, to contact consumer reporting agencies and other persons and to secure consumer reports and other information about me. I (we) authorize and direct any consumer reporting agency or other persons to furnish to the hospital and/or Physicians Group such information about me (us) that it has or obtains. I certify that the above information is true and accurate to the best of my knowledge. Further, I will direct any assistance (Medicaid, Medicare or other insurance coverage and /or insurance settlements) which may be available for payment of my hospital and/or Physicians Group charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pass to the hospital and/or Physicians Group the amount recovered for hospital and/or Physicians Group charges. I also understand that if the information which I submit is determined to be false, such a determination will result in denial of providing financial assistance services, and that I will be liable for charges for services provided. If you are eligible for a reduction of your bill, the amount you may owe will be determined by a sliding scale based on the Federal Poverty Guidelines.

Applicant Signature____Date ________________________

Co-Applicant Signature_______________________________________Date ________________________

Approved ____Date _________________________

Financial concerns can interfere with recovery simply because patients don't understand why and how they are charged. Please familiarize yourself with the terms of your insurance coverage to help you understand the hospital and/or Physicians Group billing procedures and charges.

Labette Health provides care to all people regardless of their ability to pay. This application may provide assistance if you have no insurance, or have financial difficulty with an unpaid balance at Labette Health.

For questions about the financial assistance call: (620) 820-5257.

APPLICATION REQUIREMENTS

1. A fully completed and signed Application for Financial Assistance.
2. Copies of all your income for the three months prior to date of this application for all persons living in the household must accompany your completed application.
3. A copy of last year's income tax return to verify all sources of income.
4. Social Security cards can be used to verify family size.
5. Verification that all insurance proceeds have been paid to Labette Health, including settlements.

Ways to return your application: you can mail it, fax it, e-mail or return it in person.
Labette Health
Attn: Financial Counselor
1902 S. US Hwy 59
Parsons, KS 67357

Fax: (620) 820-5485

E-mail: financialcounselor@labettehealth.com

In person: the Business Office (registration area) at Labette Health

Please note only accounts from Labette Health Physicians Group for this current year will be considered for financial assistance. Also, please be aware that payments must be made on your accounts during the application process until you are notified of approval or denial.

Financial Arrangement Agreement
Hospital and/ or Physicians Group

Please check one of the following:

A. INSURANCE PLAN

1.________I have Insurance, but do not have the policy information with me. I understand it is my responsibility to provide this information to the Hospital and/or Physicians Group within 48 hours. I assume any and all financial responsibility for this Hospital and /or Physicians Group visit.

INSURANCE COMPANY_____________________________POLICY #____________________

B. CASH PLAN
I do not have insurance. Please check one of the following

1.________I will pay my account in full when leaving the hospital and/or Physicians Group.

2.________I would like to pay__________now and make payment arrangements for the balance

3.________I would like to make payment arrangements.

4.________I would like assistance with the Application for Financial Assistance.

5.________Payroll Deduct (Labette Health employees only)

6.________I would like to combine this account with another account that is already set to terms. I understand I will need to increase my monthly payment amount to qualify.

Please Date, Print and Sign below:

Date______/______/______

____ _______________
Name of Patient (PRINT) Account Number

____
Signature of Patient or person assuming financial responsibility