

 **Application for Financial Assistance Physicians Group**

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**Parsons, Cherryvale, Independence, St. Paul, Oswego, Erie, Chanute, Chetopa, Coffeyville, Altamont**

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| Name Occupation |
| Phone Family Size |
| Street City State Zip |
| Date of Birth  |

**Please list all household members' names and date of birth**

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**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 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 is has or obtains. I certify that the about 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 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 base on the Federal Poverty Guidelines.

Applicant Signature Date

Co-Applicant Signature Date

Approved Date

