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.
- ☑ Meet with CHC representative to review application and determine assistance benefits.

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

Pittsburg Dental:
924 N. Broadway
Pittsburg, KS 66762
Ph: (620) 231-6788
1-866-396-6788
Fax:(620) 231-2331

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

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

Iola:
1408 East Street
Iola, KS 66749
Dental Ph: (620) 365-6400
Dental Fax: (620) 380-6215
Medical Ph: (620) 380-6600
Medical Fax: (620) 380-6215

Coffeyville:
604 S. Union
Coffeyville, KS 67337
Ph: (620) 251-4300
Fax: (620) 251-4979

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

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

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 letter verifying this status is required. You must return this application to CHC for review by a staff member who will determine if you are eligible for a discount.

What benefits do you offer?

We strive to give 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. Depending on your income and the services you require, you may pay as little as $15 for medical services, $25 for mental health care, $35 for dental care, $25 for walk in care, and $25 for optometry. If your monthly household income is at or less than the amounts below, you are eligible for a discount.

Monthly Gross Income Guidelines					
Amount owed*	$15/25/35	$25/35/45	$35/45/55	$45/55/65	100% of Charges
Family of 1	$1,188	$1,386	$1,683	$1,980	$1,981 and higher
Family of 2	$1,602	$1,869	$2,270	$2,670	$2,671 and higher
Family of 3	$2,016	$2,352	$2,856	$3,360	$3,361 and higher
Family of 4	$2,430	$2,835	$3,443	$4,050	$4,051 and higher

How long will my discount last?

Your discount will be in effect for 12 months. If your income or household size 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 claim is denied, we will then apply your discount to the total amount. 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

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_____

Household Information: List everyone living in your home starting with yourself (including unborn children).

Name	Birthdate	Relationship to you
1		
2		
3		
4		
5		
6		
7		

Household Income Information: Please list everyone in the household receiving income. (*Household income includes all income generated by the household, regardless of marital status. 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 working or receiving income	Type of income (employment, SSI, benefits, etc.)	Employer name and phone number	Average Weekly Hours	How often is this paid? What day?

Health Insurance Information: Please list anyone in the household 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: Authorized Household Representative Date

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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

$_____

Corrections

Corrections Made: Date: _____

Actions Taken Date: _____

Signature: _____

Reviewed By (Print Name/Date):

_____ _____