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)

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