



# Community Health Center of Southeast Kansas

## Financial Assistance Application

Community Health Center of Southeast Kansas, Inc. (CHC/SEK) provides quality health care to all, regardless of ability to pay. This application may provide assistance if you have difficulty paying for services.

**If you have any questions regarding your Financial Assistance Application contact:**

CHC/SEK – Financial Assistance at (620) 240-5682 or [fa@chcsek.org](mailto:fa@chcsek.org).

**Return your completed Financial Assistance Application to:**

CHC/SEK - Financial Assistance, P.O. Box 1832, Pittsburg, Kansas 66762

Fax Number: (620) 231-2808

Email: [fa@chcsek.org](mailto:fa@chcsek.org)

**You may deliver your application to ANY CHC/SEK clinic.**

**A completed Financial Assistance Application includes:**

- A Filled-out and signed Financial Assistance Application (please print clearly).
- All supporting documents (proof of income, proof of address).

**You can qualify for Financial Assistance if you have health insurance; so, please complete the Financial Assistance Application regardless of your health insurance status.**

**CHC/SEK applies presumptive eligibility, which allows you to qualify for Financial Assistance while your Financial Assistance Application is being processed.**

**A determination on whether you qualify for Financial Assistance will be made within seven (7) days of the submission of your completed Financial Assistance Application.**

**Your Financial Assistance will last for one (1) year from approval of your Financial Assistance. After the year, you will be need to complete a new Financial Assistance Application.**

**Please see CHC/SEK’s website, [www.chcsek.org](http://www.chcsek.org), for additional information on CHC/SEK’s Financial Assistance Program.**

**Income Self-Declaration:** No proof of my income is available. Given no proof of my income is available, I declare that my annual income is \$\_\_\_\_\_ I have no proof of my income because \_\_\_\_\_.

**Patient/Guardian Name (Print):** \_\_\_\_\_

**Patient/Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)