



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): <input type="checkbox"/> 1, <input type="checkbox"/> 2, <input type="checkbox"/> 3, <input type="checkbox"/> 4, <input type="checkbox"/> 5, <input type="checkbox"/> 6, <input type="checkbox"/> 7, <input type="checkbox"/> 8, <input type="checkbox"/> Other: _____	
Name	Date of Birth	Name	Date of Birth
PATIENT (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)

