Cheyenne County HOSPITAL

"Improving Health through Access to Quality Care"

Financial Assistance Application

Effective October 18, 2024, we have implemented the following changes to our Financial Assistance Policy:

- The application period for completion of a financial assistance application is available for a minimum of 240 days from the date Cheyenne County Hospital provides the patient with the first post discharge billing statement for patient services.
- Once the patient has qualified, they are eligible for 365 days (one year).
- Patients are eligible based on family size and household income. The household income must be less than 200% of the poverty level to receive 100% financial assistance.
- The Application process includes completion of a "Financial Assistance Application Form" and providing verification documents. Verifiable information may include, but is not limited to, the following:

    - Individual or family income (income tax return with copies of earnings statements - W-2 forms, 1099 forms, etc. for past 2 years)
    - Copies of most recent 90 days of payroll stubs, Social Security checks, or unemployment checks.
    - Household family size

If you have any questions about the Financial Assistance Policy, please feel free to contact our Financial Counselor, Marla Ross at (785) 332-2104.

OFFICE USE ONLY

Patient Pays _____
Guarantor# _____

Valid Date __ __ __ __ __ __
Initials __ __ __ __

Effective through_____

Cheyenne County Hospital
Financial Assistance Program
Information Form

(PLEASE PRINT)

NAME: .....

ADDRESS: .....

FAMILY SIZE: .....

NAMES OF ALL FAMILY MEMBERS: (currently living in the same household)

_____ Relationship: .....

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Proof of income must be submitted in order to qualify for the Charity Care Program. Examples of proof would be: Tax returns from last year, Payroll stubs, W-2 forms. For households with 2 working adults, we must have both person's payroll stubs and/or W-2 forms if those were the proof of income used to qualify.

CHARITY CARE QUALIFIES ARE TO BE REVIEWED ON AN ANNUAL BASIS OR IF INCOME INFORMATION CHANGES FOR CONTINUED QUALIFICATION.

I understand the above information and believe it to be true and correct to the best of my knowledge. Anyone providing false information for qualification will be terminated from the Charity Care Program and will be subject to full charges retroactive to the prior months when false information was provided.

SIGNED ..... DATE: .....

Financial assistance application form

Patient information

(Please print and all fields must be completed. Indicate N/A if not applicable on any individual line in the application)

Date_____ Account number _____

Name (first and last)_____

Birth date_____ Marital status (optional): _____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Responsible party's information/legal guardian's information

(If patient above is same as responsible party, leave this section blank.)

Name (first and last)_____

Birth date_____ Marital status (optional): _____ Phone number _____

Mailing address_____ City_____ State_____ ZIP_____

Social security number (optional) _____

Employer_____ Employment status_____

Number of hours worked per week_____ Employer phone number_____

Other Adults in Household

(If patient is same as responsible party, fill in other adults in household information.)

Name (first and last)_____

Birth date_____ Marital status (optional): _____ Phone number _____

_____ Mailing address_____ City_____

_____ State_____ ZIP_____ Social security number (optional) _____

_____ Employer_____

_____ Employment status_____ Number of hours worked per week_____ Employer phone number_____

Dependents of responsible party

(If patient is same as responsible party, fill in spouse/partner information for patient.)

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Name_____ Birth date_____ Relationship to responsible party _____

Number of adults and children living in household _____

Monthly income

(Fill in dollar amounts for each item listed below. Provide amount per month for each.)

Applicant earned income _____

Other working adult income: _____

Social security benefits _____

Pension/retirement income _____

Disability income_____

Unemployment compensation _____

Worker's compensation _____

Interest/dividend income _____

Child support received _____

Alimony received _____

Rental property income _____

Food stamps _____

Trust fund distribution received _____

Other income _____

Other income _____

Total gross monthly income $ _____

I hereby certify that the above information is true and complete to the best of my knowledge.

Signature of Applicant_____

Date _____