Uncompensated Care Application

The attached information is necessary for us to reach a decision regarding your account(s). Failure to supply requested information could hinder processing and may result in your account(s) being sent to collections. Information received will be regarded as confidential and used only for determining financial status.

Please include the following information with your application to aid us in determining your financial status:

1. Present source of income (copy of last four paycheck stubs) or statement from employer verifying wages.
2. IRS W-2 issued during the past year.
3. Last two months entire bank statements for checking, savings, money market, and investment accounts.
4. Written Statements for the most recent two months for all other income (Unemployment Compensation, disability, retirement, in-kind assistance etc.)
5. Most recent tax return
6. Documentation of asset values (residence, vehicle, etc.) including without limitation, property tax statements.
7. Most recent utility bill, rent/mortgage payment, and vehicle/loan payments.

The completed form should be returned within fifteen days of receipt. If you have questions or concerns, please contact our patient accounts manager, Beverly Hendrick at (620) 842-5111, extension 121.

I hereby certify that all information is true and correct to the best of my knowledge. I understand that the information given will be used to ascertain my ability to pay for services provided by Anthony Medical Center and/or Anthony Primary Care Clinic. I grant permission for Anthony Medical Center and/or Anthony Primary Care Clinic to verify the information provided herein.

Signature _____ Date _____

Excellence in Care
Anthony
Medical Center

Section I – Contact Information

Patient Name _____

Guarantor Name _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Employer _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Spouse Name _____

Spouse Employer _____ Telephone # _____

Address _____

City _____ State _____ Zip _____

Section II – Monthly Income

Source	**Amount**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Total Monthly Income	_____

Section III – Monthly Expense

Expense Item	Bank/Company	Balance	Monthly Payment
Home Mortgage			
Vehicle Loan #1			
Vehicle Loan #2			
Credit Card #1			
Credit Card #2			
Medical Bills			
Other Loan(s)			
Rent Payment			
Auto Insurance #1			
Auto Insurance #2			
Utilities (Electric)			
Utilities (Gas)			
Telephone			
Cell Phone			
Cable/Satellite TV			
Internet Service			
Groceries			
Child Care			
Auto Fuel			
Life Insurance			
Other			
Total Monthly Expenses			

Section IV – Summary

Total Monthly Income	
Total Monthly Expense	
Income Less Expense	

Section V – Assets

Asset	Bank/Company	Account #	Acct. Balance
Checking #1			
Checking #2			
Savings #1			
Savings #2			
CD #1			
CD#2			
Other Investments			

Property	Property Information	Estimated Value	Unpaid Bal.
Residence	Address		
Rental Property	Address		
Vehicle #1	Model/Year		
Vehicle #2	Model/Year		
Land	Address		
Other			

For Hospital/Clinic Use Only

SEE ATTACHED PRINTOUT FOR ITEMIZATION OF ACCOUNTS.

Date application received by hospital/clinic _____

Amount of payment Approved:

Hospital $_____

Clinic $_____

Reason for Denial _____

Date of approval or denial by Finance Committee _____

Date of approval or denial by Board of Directors _____

_____
Chief Executive Officer