



Morris County Hospital
600 N Washington
Council Grove, KS 66846
(620) 767-6811
Fax (620) 767-5611

APPLICATION FOR FINANCIAL ASSISTANCE

Morris County Hospital utilizes the current Federal Poverty Guidelines (attached) for income and family size to make determinations for financial assistance eligibility. The Board of Trustees and the Administration of the hospital have established a tiered guideline as the criterion that is to be followed when granting financial assistance.

The hospital administration must have certain facts about your personal financial situation so it may make a reasonable judgment about your ability to pay your bill.

The following documents must be submitted along with the application in order for the application to be considered.

- 1. Copies of your Federal Income Tax Returns for the past 3 years.*
- 2. Current pay stub showing your year-to-date earnings.*

OR

If you are retired and rely solely upon Social Security payments for your income then we will need copies of the letters from the Social Security Administration indicating what your annual payment amount will be for the current year.

Submitted Financial Assistance Requests will be reviewed by the Chief Financial Officer and if the application meets the criteria as approved by the Morris County Hospital Board of Trustees it will then be sent to accounts receivable for processing. The patient will then be notified of the outcome of their request.

I understand that the information, which I submit, is subject to verification by Morris County Hospital and others as requested. I certify that the information submitted is true and correct to the best of my knowledge.

Signed: _____ Date: _____

Morris County Hospital Financial Assistance Program

Patient and/or Guarantor Name: _____

Current Address: _____

Social Security Number: _____

Balance of accounts due to the hospital: _____

Income Verification is Required for Processing This Application

Name of Employer: _____

Phone Number of Employer: _____

Monthly Salary/Wages: _____

Spouse's Employer: _____

Phone Number of Employer: _____

Monthly Salary/Wages: _____

Other Family Income: _____

Monthly Expenses

Rent/House Payment: _____ Utilities: _____

Medical Expenses: _____

Loan Payments: _____

Credit Card Payments: _____

Other Household expenses: _____

Total Monthly Expenses: _____

Number of Persons in the family	2017 Poverty Guideline	150% of 2017 Guideline	200% of 2017 Guideline
1	12,060	18,090	24,120
2	16,240	24,360	32,480
3	20,420	30,630	40,840
4	24,600	36,900	49,200
5	28,780	43,170	57,560
6	32,960	49,440	65,920
7	37,140	55,710	74,280
8	41,320	61,980	82,640
Level of Assistance:	100%	50%	25%

For families with more
than 8 persons, add
\$4,160 for each additional
person.

Prepared by:

Ron Christenson, CFO

Approved by:

MCH Board of Trustees

Date Approved: 2-20-08