Patterson Health Center
485 N KS HWY 2
Anthony, KS 67003
620.914.1200
pattersonhc.org

UNCOMPENSATED CARE APPLICATION

Patterson Health Center is dedicated to providing quality health care to our patients. We realize that payment of those services may be a financial hardship for you at this time. Therefore, we are offering you the opportunity to apply for financial assistance. Below you will find an application that demonstrates your financial situation. You must complete this document in full to receive consideration for our financial assistance program. If your financial situation meets the criteria set forth by Patterson Health Center, part or all your account balance may be forgiven. Information received will be regarded as confidential and used only for determining financial status.

In addition to a completed application please provide the following:

- Copy of your most recent Federal 1040 tax return, including all applicable schedules.

And one of the following:

- Copy of last two pay stubs for any wage earner contributing to household income
- Social Security Awards Letter or most recent 1099 if receiving Social Security (If you are receiving Social Security as well as have other income, please provide proof of additional income)

The completed form should be returned within thirty days of receipt. If you have questions or concerns, please contact the business office at (620) 914-1200 option 2.

I hereby certify that all information and supporting documentation is true and correct to the best of my knowledge. I understand that the information provided will be used to ascertain my ability to pay for services provided by Patterson Health Center. I grant permission for Patterson Health Center to verify the information provided herein. Patterson Health Center has made no representations that financial assistance is guaranteed.

Name(Print)_____Signature_____Date_____

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Demographics

Name:_____ Date of Birth:_____ Social Security #:_____

Spouse Name:_____ Date of Birth:_____ Social Security #:_____

Guarantor name:_____ Date of Birth:_____ Social Security #:_____

Address_____ City:_____ State:_____ Zip Code:_____

Cell Phone (Guarantor):_____ Cell Phone (Spouse)_____

Please list all dependents under the age of 18 living in your household:

Name:_____ Date of Birth:_____ Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____ Name:_____ Date of Birth:_____

Name:_____ Date of Birth:_____ Name:_____ Date of Birth:_____

Income

Self	Monthly Gross Income	Spouse
$	Gross Income/Unemployment/Work Comp	$
$	Social Security/SSI/SSDI	$
$	Self-Employment/Rental Income/Royalties/Estates/Trusts	$
$	Retirement/Pension/Annuities/Veteran's Benefits	$
$	Child Support/Spousal Support/Public Assistance	$
$	Miscellaneous/Other Income:_____	$
$	**Total Income (Please provide proof of all income)**	**$**

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In the following space, PLEASE WRITE AN EXPLANATION OF YOUR CURRENT FINANCIAL SITUATION. If you do not have enough space, please write additional information on back of this sheet.

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For Internal Office Use Only:

Date application received by Patterson Health Center_____

Account Balances eligible for Uncompensated Care:

Hospital_____

Clinic_____

Total_____

Discount % approved:_____

Discount amount approved:_____

CEO Signature:_____ Date:_____

If account balance $2,000 or more:

Finance Committee Signature_____ Date:_____

Updated 1-6-22 - LA