GIRARD Medical Center
302 North Hospital Drive • Girard, KS 66743 • PHONE 620.724.8291 • FAX 620.724.6332
GirardMedicalCenter.com
#1 In Service

Dear Patient,

Girard Medical Center provides financial assistance for emergent and medically necessary healthcare services to those who qualify.

Please complete the application and return it to the Patient Accounts Manager. All required documents must be included or the application will be denied. You will receive a response in writing regarding the outcome within 10 business days.

Until your application is processed you must continue to make your scheduled monthly payments.

Should you have any question or concerns feel free to contact me directly.

Sincerely,

Debbie Maxwell
Patient Account Manager
620.724.5156

GIRARD MEDICAL CENTER
APPLICATION FOR FINANCIAL ASSISTANCE

Please provide copies of your most recent 1040, three months of current pay stubs and medical assistance notice of denial. (The taxes and current pay stubs will apply to all members of the household.) Applications will be considered incomplete and returned if this information is not included.

General Information:

Responsible Party _____ SSN_____

Address/Phone_____

Spouse/Other Party _____ SSN_____

Address Phone_____

Patient Name(s) _____

Number of Children in the home (under 18, list ages) _____

Income:

Gross Monthly Salary (Responsible Party/Head of Household)_____

Employer/Address (Responsible Party/Head of Household) _____

Gross Monthly Salary (Spouse/Other Party) _____

Employer/Address (Spouse/Other Party)_____

Assets:

Checking Account Balance _____ Bank _____

Savings Account Balance_____ Bank _____

Home value _____ Car(s) value _____

Other (IRA, stocks, 401K, etc.)_____

_____

Expenses (monthly):

Rent or Home Mortgage Pmt _____ Utilities_____

Car Payment(s) _____ Credit Card Payment(s)_____

Other Loan Payment _____ Medical Bills _____

Insurance Premium _____ Other _____

Medicine_____ Other _____

References:

Please list two relatives and one friend not living with you. Include name, address, phone number and relationship.

1. _____

   _____

2. _____

   _____

3. _____

   _____

NOTICE OF NON-DISCRIMINATION POLICY: Girard Medical Center does not discriminate on the basis of race, color, national origin (including individuals with limited English proficiency), sex (including gender identity), age or disability in health programs or activities and is compliant with Section 1557.

I certify that the above information is true and correct to the best of my knowledge and further agree that falsification herein will disqualify me or my dependent(s) for charitable services. I understand the information submitted is subject to verification; therefore I authorize Girard Medical Center to obtain information from my creditors listed above and understand that Girard Medical Center may request a credit report on all responsible parties.

_____

Signature of Responsible Party Date

_____

Signature of Spouse/Other Party Date