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

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

This program is based on income, Federal Poverty Guidelines, and available assets. To be considered, please complete the application and return it to the Patient Accounts Manager with all required documents. Partial applications will be returned.

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

We are available to assist you with any questions Monday-Friday 8:00am - 4:30pm at 620-724-5153. You may return your application in person or by mailing to:

Girard Medical Center
Attn: Patient Account Manager
302 N Hospital Dr
Girard, KS 66743

Sincerely,

Sean Staton
Patient Account Manager
620.724.5153 Phone
620.724.5195 Fax

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Documentation Checklist:

- ☐ Income tax return for most recent year (must include all pages). If you do not file taxes please explain: _____

  _____

  _____
- ☐ Last 3 months of income documentation (including payroll, unemployment, pension, commissions, bonuses, farm, sales, or any other income you receive)
- ☐ Last 3 months of bank statements
- ☐ Official Social Security and/or Social Security Disability Benefit award letter for the current year (if applicable)
- ☐ Documentation of Child Support received (if applicable). You can obtain this information from the KPC website.
- ☐ Application completed in its entirety and signed by all responsible parties including the spouse if you are married.
- ☐ If you are unemployed or have no income, please explain on a separate sheet of paper how you meet your day to day needs such as food, transportation, shelter, etc.

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Financial Assistance Application

Responsible Party: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Marital Status: _____

Please list all persons living in the household, including the responsible party.

Name	Relationship to Responsible Party	Date of Birth	Social Security Number	Claimed on attached Tax Return (Y or N)

Explain your situation or need for Financial Assistance:_____

_____

_____

_____

_____

Income	Responsible Party	Spouse / Significant Other
Gross		
Self-Employment		
Social Security		
Pension		
Unemployment		
Other		

ASSETS

Checking Account Balance: _____ Bank: _____

Savings Account Balance: _____ Bank: _____

Home Value: _____ Car(s) Value: _____

Other (IRA, 401K, Stocks, Bonds, Etc): _____

MONTHLY EXPENSES

Rent/Mortgage: _____ Utilities: _____

Car Payment: _____ Other: _____

Applicant Acknowledgement:
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