Rawlins County Health Center
Financial Assistance Application

It is the policy of Rawlins County Health Center to provide essential services regardless of the patient's ability to pay. Discounts are offered based upon family size and household income. Please complete the following information and return to the Business Office to determine if you or members of your family are eligible for a discount.

SLIDING FEE SCALE: The sliding fee scale discount will apply to all services received at the Rawlins Clinic, but **NOT** those services which are performed at the Rawlins County Health Center (Hospital), and not limited to but including reference laboratory testing, drugs, radiology interpretation by a consulting radiologist, and other such services. This form must be completed each year. If your income changes, you may request to complete a new application. Please inquire at the front desk if you have questions.

Name of Head of Household:			Place of Employment:	
Street:	City:	State:	Zip:	Phone:
Health Insurance Plan:			Social Security Number (optional):	

LIST BELOW ALL MEMBERS OF HOUSEHOLD
(BEGINNING WITH HEAD OF HOUSEHOLD)

	Name (First/Last)	Date of Birth	Relation to Patient
Self:			
Spouse:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			
Dependent:			

ANNUAL HOUSEHOLD INCOME

Source	Self	Spouse	ALL Other Household Members (18 & Older)	Total
Gross wages, salaries, tips, etc.				
Social security, pension, annuity, and veteran's benefits				
Alimony, child support, military family allotments				
Income from business, self-employment, and dependents				
Rent, Interest, dividend, and other income				
Total Income				

I certify that the family size and income information shown above is correct. Copies of text returns, pay stubs, and other information verifying income may be required before a discount is approved.

_____ _____ _____

Name (print) Signature Date

ADDITIONAL FINANCIAL ASSISTANCE:

PLEASE SUBMIT TO THE RCHC BUSINESS OFFICE:

1. Individual or family income tax returns for everyone over 18 in the household (include earnings statements, W-2s, 1099s, etc.) for the past 2 years.
2. Payroll stubs, Social Security checks or unemployment checks from the last 90 days.
3. In Absence of Income send a letter of support from the individual providing for the patient's basic living needs
4. Documentation of employment status.

Do you have health insurance coverage available? Yes/No

If yes, why is it not available for this date of service?

_____

If no, please indicate the reason or lack of insurance coverage.

Insurance cost too high? Yes/No Pre-existing condition? Yes/No

Other, please describe: _____

Have you applied for Medicaid? Yes/No Date Applied: _____

If denied, date: _____

Reason for denial: _____

If denied, please attach a copy of the Medicaid denial letter.

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

_____

_____

_____

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I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFOMRATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature: _____ Date: _____