**Community Hospital Association**

**Community Hospital Fairfax-Family Medicine Clinics**

**PO Box 107 - Fairfax, MO 64446**

**Lacey Barrett, Patient Financial Counselor – 660-686-2326/fax 660-686-2799**

**Application and Determination**

Applicant Name and Physical Address: Home Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List everyone living at the above residence.

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| --- | --- | --- | --- |
| **Name** | **Relationship** | **Date of Birth** | **Insurance Coverage** |
|  | Self |  |  |
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**Please provide the following information that applies:**

 **Wages:** ***Written verification of family income:*** Check stubs dated for 1-month wages prior to application date reflecting gross income for applicant and spouse. A document signed by your employer showing gross wages is also acceptable.

 **Self-Employed:** Prior year income tax return and business asset/liabilities statement.

 **Social Security Income (SSI):** Document from Social Security Office showing monthly benefit amount that will reflect gross income or a copy of your most recent bank statement if your SSI is direct deposited.

 **Pension Income:**  Copy of monthly check or a document from fund/payers’ office showing the monthly payment amount or most recent bank statement if pension is direct deposited.

 **Child Support/Alimony**: Document from child support enforcement office showing amount of money collected for child support during past 3 months or divorce decree/child support showing monthly payment amount.

**\*\*IF NO INCOME PLEASE PROVIDE A STATEMENT STATING YOU ARE UNEMPLOYED AND HOW YOU ARE COVERING YOUR EXPENSES\*\***

**\*APPLICATIONS WILL NOT BE PROCESSED UNTIL ALL INFORMATION IS RETURNED. \***

**I certify that the above information is true and correct to the best of my knowledge.**

Date \_\_\_\_\_\_\_\_\_\_ Applicant Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*\*Services not eligible for* ***CLINIC*** *discounts are, Motor Vehicle Accidents, DOT Physicals, Sports Physicals, Workers Comp Claims, OB appointments except for the 1st visit, any labs sent to Quest, and Elective Procedures. \*\**

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| **(For Office Use Only)**  |
| Verification Staff: | Date: | Total Income $ | Co-Pay Level $ |