CLOUD COUNTY HEALTH CENTER
1100 Highland Dr., Concordia, KS 66901

REQUEST FOR FINANCIAL ASSISTANCE

As provided by Federal law, I ask CCHC to determine if I am eligible for help in paying for my hospital bill. I understand that I need to give certain information for this to be done. I also understand that these facts will be checked for accuracy by CCHC or its agents. I understand that filling out this form does not guarantee that I will receive Financial Assistance. If I am not eligible for Financial Assistance, I understand that I am responsible for my hospital bill.

Name _____ Account _____

Address _____ County _____ Phone Number _____
Street City Zip

Employer Name _____ Employer Phone _____

Employer Address _____

Date of Birth _____ Physician Name _____

List Family Members Living With You:

Name	Relationship	Age

INCOME: PLEASE PROVIDE PHOTOCOPIES OF YOUR LAST TWO PAY STUBS AND LIST INCOME FOR FAMILY FROM:

		Monthly	Annual
Wages:	Self		
	Spouse		
	Other		
Farm or Self-Employment			
Balance sheet needed for Self-Employed/Farmers			
Public Assistance			
Social Security			
Unemployment Compensat			
Alimony			
Child Support			
Military Family Allotments			
Pensions			
Income from Dividends, Interest, Rent			
Other			

ADDITIONALLY, PLEASE PROVIDE COPIES OF YOUR LAST TWO BANK STATEMENTS & LAST YEAR'S TAX RETURN.

PLEASE PROVIDE COPIES OF YOUR DRIVER'S LICENSE OR OTHER FROM OF PICTURE ID

I CERTIFY THAT THE FAMILY SIZE AND INCOME INFORMATION SHOWN ABOVE IS CORRECT.

NAME (PRINT)

SIGNATURE DATE

2022 POVERTY INCOME GUIDELINES

Size of Family	Federal Poverty Guidelines (FPG)		
1	$13,590	$20,385	$27,180
2	$18,310	$27,465	$36,620
3	$23,030	$34,530	$46,060
4	$27,750	$41,625	$55,500
5	$32,470	$48,705	$64,940
6	$37,190	$55,785	$74,380
7	$41,910	$62,865	$83,820
8	$46,630	$69,945	$93,260
	Add $4,540 for each additional person.		