Lindsborg
Community Hospital
Salina Regional Health Center

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Thank you for requesting a financial assistance form. The business office personnel are willing to provide information concerning financial assistance programs to the patient or a member of the patient's immediate family.

Patient eligibility for financial assistance is determined by measuring family income against the current U.S. Department of Health and Human Services Poverty Guidelines. To be considered for assistance, **a financial statement is required** (See Financial Assistance Application). You must also **provide the following documentation verification:**

Federal tax returned for the last year filed (if a college student a FAFSA may be supplied)

OR

Income for the last six (6) months (bank statements, check stubs, written verification from employer, etc.)

In order to complete the process in a timely manner, this application and the necessary information should be returned <u>within 30 days.</u>

You may be contacted to provide more information if the information you provide is not sufficient for the review.

Upon receipt of all information requested, the hospital administration will do a review of the information you provide and you will be notified within two (2) weeks of the review decision. If you have questions or concerns, please contact the business office at (785) 227-3308, extension 114.

Thank you for choosing Lindsborg Community Hospital for your health care needs.

Sincerely,

Business Office Staff

Financial Assistance

Being a patient in the hospital can cause a financial burden on you or your family for which you are not prepared. We want to help ease this burden so that financial problems will not interfere with your recovery.

Lindsborg Community Hospital/Family Health Care Clinic's financial assistance program helps patients who have large medical bills that are beyond their ability to pay.

Any patient, whether underinsured (patients who are insured but cannot pay their portion of the bill) or uninsured (patients having no insurance or federal or state health care program) can apply to receive financial assistance for medical bills. Financial assistance is based solely on the patient's ability to pay and not on the basis of age, race, color, religion, sex, national origin, disability, or veteran status.

LCH must provide, without discrimination, care for emergency medical conditions regardless of whether a patient is eligible for financial assistance.

Application for Assistance

An Application for Assistance form is available by calling our Financial Services staff at (785) 227-3308. Representatives are ready to help you and your family with any questions or concerns you may have.

Financial Services is open Monday through Friday from 8 a.m. to 5 p.m.

Our Pledge to You

- A discount will be given to all uninsured patients.
- Lindsborg Community Hospital/Family Health Care Clinic will also provide financial assistance to patients who meet guidelines based on federal poverty levels.
- LCH/FHCC will help patients with alternative methods of financial assistance whenever possible.
- Confidentiality of information will be maintained for all who seek financial assistance with Lindsborg Community Hospital/Family Health Care Clinic.
- LCH/FHCC respects and values the dignity of all patients and their families.
- Lindsborg Community Hospital/Family Health Care Clinic maintains its commitment to serve all patients requiring care regardless of age, race, color, religion, sex, national origin, disability, veteran status or ability to pay.

LINDSBORG COMMUNITY HOSPITAL - FINANCIAL ASSISTANCE APPLICATION

605 W Lincoln, Lindsborg, KS 67456 785-227-3308

Applicant's Name

Address City State Zip

Telephone # SS # DOB

Patient's Name Patient Account #(s)

Address City State Zip

Telephone # SS # DOB

Employer Position How Long?

Address City State Zip

Telephone #

Spouse's Name SS # DOB

Spouse's Employer Position How Long?

Address City State Zip

Telephone #

Number of Family Members (Including you, your spouse, your children, and any one residing with you that you support. Also students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption are considered to be residing with those who support them.)

INCOME: LIST INCOME FOR YOUR FAMILY FROM:	Gross Income Last 6 Months	Gross Income Last 12 Months
Wages		
Public and Emergency Assistance		
Social Security		
Unemployment Compensation		
Worker's Compensation		
Farm or Self Employment		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest		
Rental Property		
Other		
Total		

Please attach proof of income (6 months of pay stubs, most recent W-2 forms, most recently file Income Tax Return, most recent FAFSA, six months of bank statements, written verification of wage from a current employer, most current written verification from a public welfare agency or other governmental agency attesting to income status.)

I hereby request that Lindsborg Community Hospital make a written determination of my eligibility for financial assistance. I certify the above information is true and correct. I understand that the information I submit concerning my income and family size is subject to verification by Lindsborg Community Hospital and hereby authorize them to do so. I further authorize the employers/institutions to release such information. I also understand that if the information I submit is determined to be false, such a determination will result in denial of providing financial assistance, and that I will be liable for charges of services provided.

_____ _____

Signature Date