SEDGWICK COUNTY MEMORIAL HOSPITAL/VALLEY MEDICAL CLINIC
Confidential Financial Assistance Application

Patient's Name_____ Date_____

Date of Birth and Guardian, if applicable_____

Have you applied for Medicare and/or Medicaid_____ Date_____

Results of the Application_____

PLEASE CHECK any circumstances listed that causes you to seek financial assistance from Sedgwick County Memorial Hospital/Valley Medical Clinic

_____ I am not eligible for Medicare, Medicaid, Veteran's benefits or any other state or federal government program

_____ I cannot afford private Health Insurance

_____ My employer does not offer health insurance benefits

_____ My employer offers health insurance, but the employee share is too high

_____ Other _____

LIST ALL members of the family, starting with the Patient:

Name	Relationship to Patient	Age	Work Place	Full or Part Time Employment

LIST ALL GROSS MONTHLY INCOME for all family members:

(Provide 1 month proof to all that apply to the family. Also provide a copy of driver's license and social security card.)

Employment (Include Tips)	$_____
Unemployment Compensation	$_____
AFDC	$_____
Child Support	$_____
Pension	$_____
Social Security	$_____
Other	$_____
Total Gross Income	$_____

PLEASE ATTACH YOUR LAST 5 PAYCHECK STUBS, OTHER PROOF OF INCOME OR YOUR LAST FILED FEDERAL INCOME TAX RETURN.

I am applying for Financial Assistance for health care services. I hereby certify that the above information is true and correct to the best of my knowledge. I also understand that the appropriate documentation must be mailed or provided with this application.

Signature_____ Date_____

Do Not Write Below This Line

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Total number in household _____ Total Household annual income $_____

Fee Category Discount: _____

Rating Technician Signature: _____ Date_____