Coffey Health System
801 N. Fourth St. • Burlington, KS 66839
(620) 364-2121 • Fax (620) 364-8425
www.coffeyhealth.org

Patient Financial Assistance Application

Agreement

To apply for the Patient Financial Assistance program, the applicant agrees to the following:

1. Responsible Party agrees to submit **all** requested information and documentation within **60 days** as this allows Coffey Health System time to verify the patient's eligibility to participate in the program. All information and documentation furnished will remain confidential. Incomplete or inaccurate documentation will not be considered for the Patient Financial Assistance program.

2. Responsible Party agrees to make monthly payments on the outstanding balance of patient account during the application process. To set up payments, contact the Business Office, (620) 364-4541.

3. The determination and award period may take up to 30 working days after the final application submission. Responsible party agrees to update or recertify any information provided to Coffey Health System in connection with the Financial Assistance Program, if during the determination and award period any data changed after the initial submission.

4. Responsible Party acknowledges they are the guarantor of the account and responsible for the charges by Coffey Health System on the patient account. An application submitted for patient financial assistance is not a guarantee of relief from amounts owed to Coffey Health System.

5. Responsible Party acknowledges they have been advised of the discounts and payment plans available under the Financial Assistance Policy. If guarantor account is not paid in full through the Patient Financial Assistance award, the Responsible Party acknowledges they are the guarantor of the account and will owe any remainder due.

6. Responsible Party acknowledges and agrees the execution of this Agreement does not guarantee participation in the Coffey Health System's Financial Assistance Program.

   Responsible Party has executed this Agreement and delivered to the Business Office Representative, Social Services, Controller or CFO of Coffey Health System.

Patient Name: (print) _____

Responsible Party (print)_____

Responsible Party Signature: _____ Date: _____

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Patient's Full Name: (L)_____(F)_____(MI)___ Date:_____

Patient's Date of Birth: _____ Patient's SSN:_____

Guarantor's Full Name: _____ Spouse or Domestic Partner_____
(if different from patient)
Street Address:_____ Mailing Address:_____
(if different)
City: _____ State:_____ Zip:_____ Employer _____

Phone Number:_____ Employer_____ Emp. Phone_____

LIST THE DETAIL OF HOUSEHOLD FAMILY ANNUAL INCOME OF ALL MEMBERS OVER 18 YEARS OF AGE:

Wages _____ Alimony _____

Farming or Self Employment _____ Child Support _____

Social Security _____ Pension _____ _____

Unemployment _____ Workman's Comp _____ _____

Dividends, Interest, Rent_____ Strike Benefits _____ _____

Public Assistance _____ Military Family Allotment _____

HOUSEHOLD ANNUAL INCOME TOTAL $_____

LIST BELOW THE TOTAL FAMILY ASSETS: $_____

Checking Account _____ Real Estate Owned _____

Savings Account _____ Automobiles _____

CD's / Securities _____ Other:

Stocks & Bonds _____ Farm Equipment / Livestock _____

LIST BELOW TOTAL OBLIGATIONS $_____

Rent or House Payment _____ Credit Card _____
Car Payment _____ Finance Companies _____
Utilities (avg) _____ Other _____

LIST ALL HOUSEHOLD MEMBERS AND AGES BELOW
#1 _____ #2 _____ #3 _____
#4_____ #5 _____ #6 _____

I CERTIFY THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND I GIVE PERMISSION TO VERITY THE ABOVE INFORMATION.
Signature _____ Date:_____

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POLICY STATEMENT

Consistent with its mission to work together to relieve suffering, restore health, and promote the highest quality of life in our community, Coffey Health System (CHS) is committed to providing charity care to individuals in need of medically necessary treatment regardless of their ability to pay. This policy is for use for individuals who do not have health insurance, and are not eligible for benefits under Medicaid, Medicare, or other entitlement or grant funding programs. Written notice of non-qualification may be requested.

QUALIFICATION GUIDELINES AND ELIGIBILITY:

Financial assistance eligibility is determined by using the Federal Poverty Level guidelines as established by the US Department of Health and Human Services. All patients may participate and will receive assistance if they meet **ALL** of the following as listed below.

1. The patient's primary residence is located in Coffey County or within 15 miles of a Coffey Health System Service Facility.
2. The patient must not possess any health insurance.
3. Must be a U.S. Citizen (an exception must be approved by the CFO or CEO).
4. Copy of the most recent year's Federal Income Tax Return, including all schedules as filed.
5. Copy of all current pay stubs.
6. Any applicable forms approving or denying unemployment compensation or Worker's compensation.
7. Written verification of denial for application for Medicaid and/or any other entitlement program if requested. This is the web site to apply https://www.kancare.ks.gov/consumers/apply-for-kancare
8. Patient Financial Assistance Applications must be completed within 90 days of service. Determination and eligibility will be made within thirty working days following submission of completed application.
9. Household income is not greater than 400% of the current year Federal Poverty Level.

2026 FEDERAL POVERTY GUIDELINES

Family Size	Annual Family Income
1	$15,960
2	$21,640
3	$27,320
4	$33,000
5	$38,680
6	$44,360

- For family units with more than 6 members, add $5,680 for each additional member.
- Students, regardless of their residence, who are supported by their parents or other relatives by birth, marriage, or adoption, are considered to be residing with those who support them.
- Assets are part of the application. If sufficient assets are found to pay the account, payment may be expected. **RETURN ALL APPLICATIONS TO CHS TO THE ATTENTION OF THE PFA COORDINATOR. ANY QUESTIONS ON COMPLETING APPLICATION, PLEASE CALL 620-364-2121 AND ASK FOR A BILLING REPRESENTATIVE, SOCIAL SERVICES or PFA COORDINATOR.**