F.W. HUSTON
MEDICAL CENTER

"We care for those you care for"

Charity Care Policy

We can help.

F.W. Huston Medical Center (dba: Jefferson County Memorial Hospital) takes pride in providing the highest quality healthcare to all patients and treats everyone with dignity and respect, regardless of their ability to pay.

We are proud to offer a financial assistance program, designed to work directly with patients to find payment solutions when necessary. Based on the Federal Register, Low Income Guidelines,(updated yearly). Financial assistance discounts are determined by a sliding scale of total household income, and is available for the medically uninsured, underinsured, financially needy individuals or families.

All applications for Charity Care shall be made on the attached form and submitted to the Business Office. Proof of income and family size shall be submitted with the application. Acceptable documents for submitting proof shall include the most recent filed Federal Individual Income Tax (1040), the most recent payroll stub (which includes year-to-date information), or other Federal or State of Kansas documents indicating those governmental entities determination that the individual meets the Federal Poverty Guidelines.

The application shall be reviewed promptly and a determination shall be made within 60 days from the time all required documentation has been received by the Hospital. The determination shall be in writing and will identify the approval or denial of the application.

Thank you for choosing F.W. Huston Medical Center for your health needs.

F.W. HUSTON MEDICAL CENTER

CHARITY CARE APPLICATION DATE_____

First Name: _____ Middle Initial: _____ Last Name:_____

Street Address: _____Apt # ____City:_____ State: _____ Zip Code:_____

Home Phone Number:_____ Alternative Phone Number_____

Patient Name (First, Middle, Last);_____

Service Date (s):_____ _____ _____ _____ _____ _____

Account Number(s):_____ _____ _____

Balance Due:$_____

Family Size				
Number of Persons Living in Household:_____				
Name (First, Middle, Last)	Relationship	Social Security Number	Date of Birth	Citizen Yes/No
1.	SELF			
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Income (Monthly)				
	Person 1	Person 2	Person 3	Grand Total
Gross Wages/Salary Copy 3 most recent pay stubs Copy of last years tax returns	$	$	$	$
Employer Name				
Phone Number				
Start Date				
Termination Date				
Unemployment	$	$	$	$
Welfare Assistance (Cash)	$	$	$	$
Social Security	$	$	$	$
Retirement Benefits	$	$	$	$
VA Benefits	$	$	$	$
Workers Compensation	$	$	$	$
Income Producing Property (Rent)	$	$	$	$
Other (Child Support)	$	$	$	$
Other	$	$	$	$
Combined Total Monthly Income	$	$	$	$

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CHARITY CARE APPLICATION DATE_____

Does your household have a checking account? Copy of most recent bank statement. Showing balance and activity for at least 60days.	☐ Yes	☐ No	Balance	$
Does your household have a savings account? Copy of recent statement.	☐ Yes	☐ No	Balance	$
Does your household have any Investments, IRA, CD's, etc.?	☐ Yes	☐ No	Balance	$
Rent/House payment per month? Who pays?	☐ Yes	☐ No	Amount per Month	$
Have you applied for Medicaid in the past 90 days?	☐ Yes	☐ No	Results?	
What utilities do you pay (who pays)? Monthly Amount?			$	
Do you have Medical Insurance?	☐ Yes	☐ No		
Insurance Company Name:				
Policy #				
Group #				
Phone #				
Address:				

List any other properties you own other than your primary residence.	Type of Property (house, car, etc)	Tax Assessed Value	Outstanding Mortgage
		$	$
		$	$

I understand that the information provided by me is subject to verification by F.W.Huston Medical Center. I understand that any false information provided by me will result in a denial of any Charity Care. I understand Charity Care will only be applied to the current balances on accounts listed if approved. Charity Care is available only after all other forms of reimbursement (health insurance, Medicaid, or third party insurance) have been exhausted.

Signature: _____ Date: _____

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CHARITY CARE APPLICATION DATE_____

To be considered for financial assistance you **must provide** the following:

1. The completed and signed Charity Care Application, you have 30 days after the service date to apply.
2. Copy of your most recent bank statement **(Showing balance and activity for at least 3 months.)**
3. Copy of your previous year's Federal Tax Return (if you file)
4. Copies of your 3 most recent pay stubs to validate household income. (If you are self-employed, provide copies of **three months** Profit and Loss Statements).
5. Supporting documentation of all forms of income. For example public assistance award or denial letters, alimony court orders, Social Security.
6. **Verification of Investment Value(s) (Stocks, Bonds, Mutual Funds, IRA, CD, 401K, Trust Funds, etc. Please verify the amount of monthly income (if any) drawn from investments.**
7. **If you are claiming no income** or there has been a recent change in your financial situation, you **must** include a letter of explanation. If someone else is paying for your food and shelter please include a letter of explanation from them. **Also**, please verify that you have no source of income and how long it has been since you have not had a source of income. Examples of verification may include but are not limited to: Current Tax Return, letter from a professional business, bank statements showing all deposits/withdrawals, Medicaid determination letter, etc.
8. Mail Application and supporting documentation to**:**

F. W. Huston Medical Center
408 Delaware
Winchester, Ks. 66097
Attn: Business Office
You must reapply for Charity Care, if you require additional medical treatment.

Please allow **60 days** for processing of your application before contacting the business office. Applications **must** be returned within **14 Business** days from the date you receive the application to the address listed above or requests may be denied. Please note that if Charity Care is granted it will only cover your medical bills from our facility. It will not apply to the bills for other medical groups, hospitals, or physicians groups . **PLEASE CONTACT THE OTHER MEDICAL GROUPS DIRECTLY TO INQUIRE ABOUT ASSISTANCE OPTIONS.**

When applying for Charity Care you are giving consent for us to make necessary inquiries to confirm financial obligations or references. If you have questions or need assistance please contact our Business Office at 844-536-9449 , Monday through Friday 8:30AM – 4:00 PM.

The Charity Care program benefits are subject to change without notice.
You may be required to pay a minimum payment for services. We cannot guarantee that you will qualify for financial assistance.

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CHARITY CARE APPLICATION DATE_____

ADDITIONAL INFORMATION