FAMILY CENTER FOR HEALTH CARE
at Citizens Health

310 EAST COLLEGE DRIVE
(785) 462-6184
FAX (785) 460-1490
"Our Family Taking Care of Your Family"

Financial Assistance Application

Answer each question.
Use "None" if applicable.

Please attach a copy of your most recent Federal tax form (1040) and your two most recent pay stubs OR your Social Security Determination Letter.

Please Return ALL Forms to:

FCHC
Attn: Valerie Ohlrogge
310 E College Dr
Colby, KS 67701

(785) 460- 1777

Patient Name: ____

Spouse's Name: ____
(If unmarried, but living together, please list their name here)

Address: ____
____
____

Phone Number: ____

Number of Children Living at Home (0-21 Yrs of age):___________________________

Number of Dependents Other Than Children Living at Home: _____________________

FOR FCHC USE ONLY:

Guarantor Name: ____

Account Number: ______________________ Balance: ___________

Account Number: ______________________ Balance: ___________

Total Account Balance: ___________

I. MONTHLY HOUSEHOLD INCOME

A. WAGES

1. Total Monthly Wages of Guarantor:________________________
   (Attach copy of two most recent paycheck stubs)

2. Employer Name:____

3. Employer Address:_______________________________________
   ____

4. Spouse's Name:____

5. Total Wages of Spouse:___________________________________
   (Attach copy of two most recent paycheck stubs)

6. Spouse's Employer Name:_________________________________

7. Spouse's Employer Address:_______________________________
   ____

II. OTHER INCOME

A. Disability Payments:____

B. Alimony/Child Support: ____

C. Retirement Benefits: ____

D. Investments Income: ____

E. Other Income: ____

III. TOTAL MONTHLY INCOME

$__________________

I STATE THAT ALL OF THE INFORMATION IS TRUE AND COMPLETE AND MAY BE VERIFIED WITH THE LISTED INSITUTIONS. I REQUEST EACH LISTED INSTITUTION TO RELEASE ALL OF MY PERSONAL ACCOUNT BALANCE INFORMATION TO FAMILY CENTER FOR HEALTHCARE IN ORDER TO VERIFY THE BALANCES/AMOUNTS LISTED.

Date: _____________ Signature of Applicant: _______________________________

PLEASE RETURN FORM AND ATTACHED
INCOME DOCUMENTS WITHIN 2 WEEKS OF RECEIVING

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