WILSON MEDICAL CENTER

CHARITY CARE INSTRUCTIONS & CHECKLIST

At your request, we have enclosed a Charity Care application. When submitting your application, please include documentation of household income. Examples of acceptable documentation include:

1. Two recent months paycheck stubs, a prior-year W-2 or tax return, Social Security or pension statement, unemployment documentation, employer verification, or other documentation of income.
2. Any hardship documents and or information

Income includes Gross wages; salaries; tips; income from business and self-employment; unemployment compensation; workers' compensation; Social Security; Supplemental Security Income; veterans' payments; survivor benefits; pension or retirement income; interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources.

You will be notified of approval or denial or if additional information is required in writing. Completed applications may be returned in person or mailed to:

Wilson Medical Center
Patient Financial Services
2600 Ottawa Road
Neodesha, KS 66757

Please direct any questions to Wilson Medical Center Business Office as follows:

Kristen Shaw (620) 325-8302

Respectfully,

KristenShaw

Patient Financial Services Coordinator

WILSON MEDICAL CENTER

CHARITY CARE APPLICATION

Wilson Medical Center

This application is for WMC Charity Care and is separate from the NHSC Sliding Fee Discount Program. NHSC Sliding Fee Discount eligibility is determined only by family size and income. Information requested below for Charity Care will not reduce, delay, or deny NHSC Sliding Fee Discount eligibility.

PATIENT / GUARANTOR INFORMATION

Patient Name: _____ Date of Birth: _____

Guarantor Name (if different): _____

Address: _____City: _____State: _____Zip: _____

Phone: _____ Account/Encounter #: _____

Please list <u>all</u> household members, including those under age 18:

Name: _____ DOB: _____

Name: _____ DOB; _____

Name: _____ DOB; _____

Name: _____ DOB; _____

Name: _____ DOB; _____

Name: _____ DOB; _____

Name: _____ DOB; _____

Name: _____ DOB; _____

CHARITY CARE REQUEST

Service date(s) or account(s) for which assistance is requested: _____.

Have you completed the WMC Sliding Fee Discount application? ☐ Yes ☐ No ☐ Not applicable

If no, PFS can provide the Sliding Fee Discount application. Charity Care review does not replace or change NHSC Sliding Fee eligibility.

FINANCIAL HARDSHIP INFORMATION

Please describe the circumstances that materially affect your ability to pay (for example, extraordinary medical expenses, catastrophic financial hardship, loss of income, or other significant circumstances):

_____

_____

_____

Optional monthly expense information (complete if it helps explain your hardship):

Housing	$_____	**Utilities**	$_____
Medical/Prescription	$_____	**Insurance**	$_____
Child/Dependent Care	$_____	**Other Essential Expenses**	$_____
Other Medical Debt	$_____	**Other**	$_____

Supporting Documentation

WMC may request reasonable documentation related specifically to the Charity Care hardship being considered, such as medical bills, notices of loss of income, or other documents supporting the circumstances described above. Do not delay a Sliding Fee Discount application while gathering Charity Care documentation.

CERTIFICATION

I certify that the information provided for this Charity Care request is true and complete to the best of my knowledge. I understand WMC may verify information reasonably necessary to evaluate this request.

Applicant/Guarantor Name (print): _____

Signature: _____ Date: _____

FOR WMC/PFS USE ONLY	
Sliding Fee determination completed:	☐ Yes ☐ No Discount: _____%
Charity Care decision:	☐ Approved ☐ Partially Approved ☐ Denied
CFO/Designee Approval:	_____ Date: _____