North Central Kansas Medical Center
155 West College Drive, Concordia, KS 66901

REQUEST FOR FINANCIAL ASSISTANCE

As provided by Federal law, I ask NCK Med to determine if I am eligible for help in paying for my hospital bill. I understand that I need to give certain information for this to be done. I also understand that these facts will be checked for accuracy by NCK Med or its agents. I understand that filling out this form does not guarantee that I will receive Financial Assistance. If I am not eligible for Financial Assistance, I understand that I am responsible for my hospital bill.

Name _____ Account _____

Address _____ County _____ Phone Number _____
Street City Zip

Employer Name _____ Employer Phone _____

Employer Address _____

Date of Birth _____ Physician Name _____

List Family Members Living With You:

Name	Relationship	Age

INCOME: PLEASE PROVIDE PHOTOCOPIES OF YOUR LAST TWO PAY STUBS AND LIST INCOME FOR FAMILY FROM:

		Monthly	Annual
Wages:	Self		
	Spouse		
	Other		
Farm or Self-Employment			
Balance sheet needed for Self-Employed/Farmers			
Public Assistance			
Social Security			
Unemployment Compensati			
Alimony			
Child Support			
Military Family Allotments			
Pensions			
Income from Dividends, Interest, Rent			
Other			

ADDITIONALLY, PLEASE PROVIDE COPIES OF YOUR LAST TWO BANK STATEMENTS & LAST YEAR'S TAX RETURN.

PLEASE PROVIDE COPIES OF YOUR DRIVER'S LICENSE OR OTHER FROM OF PICTURE ID

I CERTIFY THAT THE FAMILY SIZE AND INCOME INFORMATION SHOWN ABOVE IS CORRECT.

_____
NAME (PRINT)

_____ _____
SIGNATURE DATE

2023 POVERTY INCOME GUIDELINES

Size of Family	Federal Poverty Guidelines (FPG)		
1	$14,580	$21,870	$29,160
2	$19,720	$29,580	$39,440
3	$24,860	$37,290	$49,720
4	$30,000	$45,000	$60,000
5	$35,140	$52,710	$70,280
6	$40,280	$60,420	$80,560
7	$45,420	$68,130	$90,840
8	$50,560	$75,840	$101,120
	Add $5,140 for each additional person.		