Policy Title: Collections – Financial Assistance	Policy Number: BO 1002
Department: Fiscal Services	Date of Original: 11/2019
Manager Approval: Amber Clouse	Date of Last Revision: 12/2025
Policy Committee Approval:	Page: 1 of 10

I. Purpose

The purpose of this policy is to further the organizations mission to provide quality service and compassionate care by providing assistance to persons with healthcare needs who may be unable to pay for medically necessary care due to their financial situations.

II. Introduction

a. This policy addresses:
   i. Eligibility criteria for financial assistance;
   ii. The extent to which financial assistance will include free or discounted care;
   iii. The basis of calculating Amounts Generally Billed (AGB) to the patient;
   iv. The method for applying for financial assistance; and
   v. Methods to communicate the policy to patients and communities served.

This policy applies to medically necessary care and emergency medical treatment provided by Kingman Healthcare Center and its employed physicians and practitioners. A list of providers and practitioners who are both covered under this policy and who are not covered by this policy is maintained on our website www.kingmanhc.com (Addendum A) and is available free of charge at the Patient Accounts office and Registration Area at Kingman Healthcare Center, by calling 620-532-3147, or by mail at Kingman Healthcare Center, 750 W. D Ave. Kingman, KS 67068.

b. The following definitions are to be used when applying this policy:
   i. Uninsured – The patient has no insurance or coverage under governmental programs and not eligible for any third-party payment such as worker's compensation or third-party liability.
   ii. Underinsured – The patient has limited insurance coverage that does not provide coverage for the medically necessary care rendered or the maximum liability under insurance coverage has been exceeded.

iii. Medically indigent – Persons whom the hospital has determined are unable to pay some or all of their medical bills under this policy because their medical bills exceed 30% of the greater of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the federal poverty guidelines adopted by the hospital for free or discounted care under the policy. Expenses from non KHC providers deemed patient responsibility and not covered by assistance will be considered with documentation.

iv. Medically necessary care – Medically necessary care is defined as accepted healthcare services and supplies provided for the evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. This includes appropriate services and supplies that are neither more nor less than what the patient requires at a specific point in time. Medically necessary care must reflect the efficient and cost-effective application of patient care including, but not limited to, diagnostic testing, therapies (including activity restrictions, after-care instructions and prescriptions), disability ratings, rehabilitating an illness, injury, disease, or its associated symptoms, impairments or functional limitations, procedures, psychiatric care, levels of hospital care, extended care, long-term care, hospice care, and home health care. Financial assistance is not available for elective services otherwise classified as non-covered or not-medically-necessary by CMS/Medicare or DHHS/Medicaid.

c. Emergency medical treatment will be provided without regard to ability to pay and regardless of whether the patient qualifies for financial assistance under this policy. Emergency medical treatment will be provided in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) and the requirements of Section 501(r) of the Internal Revenue Code. All determinations of financial assistance eligibility and financial assistance practice in general shall be consistent with Section 231 (h) of the Health Insurance Portability and Accountability Act and shall be made in a manner consistent therewith. There will be no discrimination against patients based on ability to pay in the provision of emergency medical treatment.

d. Financial Assistance is a resource of last resort. The hospital reserves the right to allow or disallow assistance based on the patient's or guarantor's ability to pay as determined in the financial investigation process set forth herein. Furthermore, the hospital reserves the right to deny financial assistance for the failure of patient to take reasonable steps in making application for Medicare, Medicaid, and other governmental medical assistance programs in which they may be entitled to participate, and for the failure to comply with the terms and conditions of this policy.

e. The hospital Board of Directors may annually determine reasonable financial caps on the amount of financial assistance that will be provided by the hospital during the year.

III. Policy

a. Eligibility Criteria

i. General eligibility – Eligibility for financial assistance will be considered for the patient who:

1. Are uninsured or underinsured
2. Are ineligible for any government healthcare program
3. Complete the required application
4. Are deemed unable to pay for care based on financial need as determined upon review of a completed application.
   Financial assistance is available to those who meet guidelines regardless of age, sex, religion, or national origin.

ii. Presumptive Eligibility – Medicaid patients are considered pre-enrolled for financial assistance. However, a completed application is required for determine of level of possible assistance with copayments.

iii. Medically Indigent – To qualify as Medically Indigent, the patient must have medical bills in excess of 30% of the greater household income or assets (see definition).

b. Limitation of Charges and Calculation of Amount Generally Billed (AGB)

i. Calculation of AGB
Once an individual has been determined eligible for assistance, that individual will not be charged more for eligible services than the amount generally billed (AGB) to those who have insurance coverage. KHC determines AGB by multiplying the gross charges for care provided to

patients by the AGB %. KHC has elected to use the look back method in which the AGB % is based on Medicare fee for service and all private insurance. This AGB is calculated by dividing the total of all claims allowed by Medicare fee for service and all private insurance as during the prior 12-month period by the total gross charges for those claims. This AGB is updated annually and is available free of charge at the Patient Accounts office at Kingman Healthcare Center, by calling 620-532-3147, or by mail at Kingman Healthcare Center, 750 W. D Ave, Kingman, KS 67068.

ii. Amount of Financial Assistance
Charity Care Discounts – Financial assistance will be considered in accordance with this policy to patients who are uninsured or underinsured and who have household incomes less than 200% of the federal poverty guidelines or in the alternative, patients who are determined by the hospital to be medically indigent. The hospital will use poverty guidelines published in the spring of each year by the U.S. Department of Health and Human Services as the basis for a sliding scale of financial assistance determination (See Addendum C). Patients who qualify for financial assistance as medically indigent will be responsible for their medical bills up to 30% of the greater family or household income or assets. Any remaining amount will be considered financial assistance under this policy. Discounts granted to eligible patients under this policy will be taken from gross charges.

c. Application Process
   i. For the purposes of this policy, the "Application Period" beings on the date the care was provided to the patient and ends on the later of the 240th day after the first post discharge billing statement is provided to the patient or not less than 30 days after the date KHC provides the patient the required final notice to commence extraordinary collection actions (ECAs).
   ii. Patients may obtain a copy of this policy, a plain language summary, and a financial assistance application free of charge on our website www.kingmanhc.com or in person at the Patient Accounts office at Kingman Healthcare Center, by calling 620-532-3147, or by mail at Kingman Healthcare Center, 750 W. D Ave, Kingman KS 67068 (See Addendum D).

iii. The application process can take place prior to service, at the time of service (during admissions or discharge), or after the billing process. In all cases, the patient/guarantor must state their desire to apply for assistance to Patient Financial Services.

iv. The application process includes completing a form "Application for Financial Assistance". The applicant must provide copies of their previous year income tax return, pay stubs covering their previous three months of earned income, verification of Social Security, Veterans Administration Benefits, pension payments, child support, alimony, rental income, and bank statements. If self-employed the applicant must provide income/expense records for the previous three years. Copies of other supporting evidence may be required by Patient Financial Services to substantiate information gathered on the Application for Financial Assistance such as titles, Medicaid determination, determination of guardianship, birth certificates, court-ordered child support, credit reports, etc. KHC may not deny assistance under this policy for the failure to provide information that was not required to be submitted with the application.

v. A completed application for assistance must be received during the Application Period.

vi. If the application is not complete when submitted, KHC staff will contact patient by phone and letter requesting missing information, and the application will not be processed by KHC. In such a case, KHC will proceed as set forth in III.F.4.

vii. False information on the application may result in denial or revocation of any approved financial assistance, in which all collection actions may resume.

d. Eligibility and Allowance Determination Process:

i. To determine the level of financial assistance on the sliding scale, Patient Financial Services will determine the following through review of the application.

1. Annual income level based on current employment or average; annual net business income based on three-year history if self-employed.
2. Family sized based on legal dependency as defined by Internal Revenue Service, Kansas Department of Children and Families, and court order. Non-dependent children/adults are excluded from determination of family size.

ii. If the patient/guarantor qualifies for assistance, the remaining balance due may be paid by installment payments using the guidelines of the hospital policy on Collections of Self Pay Balances. The patient/guarantor must agree to accept responsibility for payment of the remaining liability in order to qualify for charity write-off and indicate
iii. their acceptance by signing under the "Certification" of the last page of the Application for Financial Assistance.

e. Accounting for Financial Assistance
   i. Write-off charity will not occur until the hospital has received payment from all other available sources.
   ii. Amounts written off to financial assistance will be accounted for separately from bad debt and contractual allowances.
   iii. Amounts written off to financial assistance may be reported separately on the income statement presented to the Board of Trustees.
   iv. Two or more signatures may be required for final approval of financial assistance based on the following limits:

Write-Off Amount	Required Signatures
$0.00 - $5,000	CFO
$5,001 - $10,000	CFO
$10,000 +	CEO & CFO

The individual above shall be responsible to determine whether KHC has taken reasonable efforts to determine whether the patient is eligible for financial assistance prior to taking any extraordinary collection actions.

f. Collection Actions – Kingman Healthcare Center will engage in reasonable efforts to determine whether an individual is eligible for assistance under this policy before engaging in extraordinary collection actions ("ECA").
   i. ECA includes any actions taken that require a legal or judicial process in an attempt to collect payment from an individual covered under this policy.
   "ECA that require legal or judicial process include, but are not limited to:
      1. Placing a lien on an individual's property;
      2. Foreclosing on an individual's real property;
      3. Attaching or seizing an individual's bank account or any other personal property;

      4. Commencing a civil action against an individual;

5. Causing an individual's arrest;
6. Causing an individual to be subject to a writ of body attachment; and
7. Garnishing an individual's wages."

KHC may send accounts to one or more collection agencies, but such action is not considered an ECA. Collection agencies will be held, in a written agreement, to the terms and conditions of this policy and will not take ECAs without the prior authorization of KHC.

ii. KHC will not take ECAs against an individual for at least 120 days from the date KHC provides the individual with the first post-discharge bill for care; and
    1. Provides at least thirty (30) days' written notice to the individual that:
        a. Notifies the individual of the availability of financial assistance;
        b. Identifies the specific ECA(s)KHC intends to initiate against the individual, and
        c. States a deadline after which ECAs may be initiated that is no earlier than 30 days after the date the notice is provided to the individual;
    2. Provides a plain language summary of the financial assistance policy with the aforementioned notice; and
    3. Makes a reasonable effort to orally notify the individual about the potential availability of financial assistance at least 30 days prior to initiating ECAs against the individual describing how the individual may obtain assistance with the financial assistance application process.

iii. Once an individual has submitted a complete application within the Application Period, while determining if the individual is eligible for according to the policy, KHC will
    1. Suspend any ECA against the individual, including that which was initiated by the collection agency;
    2. Not initiate any new ECAs;
    3. Make and document a determination as to whether individual is eligible according to the policy.

iv. If an individual submits an incomplete application at any time during the application period, KHC will comply with the items III, F. 1, 2 & 3 as well as the following:
    1. Suspend any ECA against the individual including that which was initiated by the collection agency.

2. Provide written notice with a copy of the policy to the individual describing the information necessary to complete the application.

The written notice will include the contact information (telephone number, and physical location of the office) of the Patient Financial Services department. The notice will provide the patient with at least 14 days to provide the required information; provided, however, that if the patient submits a completed application prior to the end of the Application Period, KHC will accept and process the application as completed.

3. If KHC does not receive the required information within the required timeframe, collection actions may resume.

g. Notification Process
   i. Once a determination of financial assistance has been authorized, Patient Financial Services will
      1. Provide the individual with a revised bill setting forth: (i) the amount the patient owes for care provided after the application of financial assistance, (ii) how the revised amount was determined; and (iii) either the AGB for the care provided or instructions on how the patient can obtain information regarding AGB for the care provided;
      2. Provide the patient with a refund for any amount the patient has paid in excess of the amount owed to KHC (unless such amount is less than $5); and
      3. Take all reasonably available measures to reverse any ECAs previously taken.
   ii. The financial assistance determination may extend up to 180 days over the course of treatment for which financial assistance was originally sought, unless there is a change in the financial or marital status of the individual.
      1. Change in marital status of the individual within the 180 days period of approval of the original application will void the original application.
      2. A new application for Financial Assistance with the supporting information of the new spouse will need to be provided for a determination.

      3. Change in financial status (i.e. lottery winning, loss of employment, etc.) within 180 days may result in a reprocessing of the original application to determine

changes in individual financial responsibility for future balances from the date of change to the end of the 180 days.

If such individual qualifies for less than 100% financial assistance, KHC will:

- Notify the individual regarding the basis for the presumptive financial assistance;
- Notify the individual on how to apply for potentially more financial assistance;
- Give the individual a reasonable amount of time to apply for more generous assistance before initiating ECAs; and
- If the individual submits a completed application seeking additional financial assistance during the later of the Application Period or the response time set forth in the notice, process the application as a new application in accordance with this policy.

h. Method of Communication
KHC will make the Financial Assistance Policy widely available to individuals through one or a combination of specific notification measures:
   i. The policy, all addenda and related documents, including plain language summary of the policy, will be posted on the website;
   ii. A conspicuous statement regarding the availability of financial assistance will be included in or on all billing statements;
   iii. The policy information will be distributed at the patient access points;
   iv. The policy information will be posted conspicuously in public areas (i.e, including registration areas, emergency department, waiting rooms, etc.)
   v. The policy and/or the plain language summary of the policy will be presented to the patient as they present for medical services, including admission;
   vi. The policy and/or plain language summary will be distributed in information with discharge materials;

vii. The policy will be mentioned when discussing an individual's bill over the telephone;
viii. The policy will be made available for public inspection and/or copying without charge at Kingman Healthcare Center, 750 W. D Ave, Kingman KS 67068 or at the KHC affiliated clinic locations from 8:00am – 5:00pm

Financial Assistance Policy – Plain Language Summary

Overview
Kingman Healthcare Center is committed to offering financial assistance to patients who have healthcare needs and may be unable to pay for all or part of their care. Patients seeking financial assistance must apply for the program, which is summarized below.

Eligible Services
Emergent, urgent, and medically necessary services provided by Kingman Healthcare Center, Family Clinic and Cunningham Clinic are covered under this financial assistance policy.

Eligibility Requirements
Financial assistance is generally determined by a sliding scale of total household income based on the Federal Poverty Level (FPL). If your household income is at or below 100% of the FPL, you may be eligible for a discount of 100%. Patients with a household income of 100%-200% of the FPL may qualify for a discount from a scale of 50% to 85%. Financial assistance may also be available for individuals determined to be medically indigent. No person eligible for financial assistance under the financial assistance policy will be charged more for medically necessary services than amounts generally billed to individuals who have insurance coverage. Financial assistance can be applied to any self-pay or self-pay after insurance balance. Please refer to the full policy for complete explanation and details.

How to Apply
The Financial Assistance Policy may be obtained at no charge by any of the means listed below. In addition, Financial Assistance Applications may be obtained, completed, and submitted as follows:
Applications can be downloaded from the Kingman Healthcare Center website: www.kingmanhc.com

Applications are located at the registration area and patient financial services department at Kingman Healthcare Center and the Family Clinic and, the registration area of Cunningham Clinic.

Request an application by calling 620-532-3147.

Request an application by mail at KHC, 750 W. D Ave, Kingman KS 67068

A patient who believes he/she may qualify for financial assistance must request and submit the completed application to one of the listed locations.

Individuals who need assistance in completing this application may contact KHC Patient Accounts at 620-532-3147 or in person at 750 W. D Ave, Kingman KS 67068 where a representative will be available to answer any questions regarding the application process, the financial assistance policy or this summary.

Board of Directors President _____ Date 9-29-2025

Adopted on 11/18/19

ADDENDUM A

Covered Providers

Services for the listed providers and practitioners are covered under the KHC Financial Assistance Policy.

- Facilities
  - Kingman Healthcare Center
  - Kingman Healthcare Center Family Clinic
  - Cunningham Clinic
  - Kingman Healthcare Center Rehab

- Physicians
  - Family Practice
    - Dr. Cherie Morris
    - Dr. Erin Baxa
    - Dr. Joseph Gerber
    - Dr. Jeremy Lickteig
  - General Surgery
    - Dr. Brady Werth
  - Sports Medicine
    - Dr. Jeremy Lickteig

- Nurse Practitioners
  - Kim Widler
  - Amy Miller
  - Jessica Blackwill
  - Logan Hageman

- Physician Assistants
  - Dusty Atterbury
  - Tyler Antenen
  - Dennis Kalmar
  - Jody Berry
  - Benjamin Kimball
  - Shawn Vredenburg

Services for the listed provider groups are NOT covered under the KHC Financial Assistance Policy.

- Cypress Heart, Dr. Alvarez
- Cardiac Monitoring Service
- Kansas Cardiac Clinic

- Heartland Cardiology, Dr. Farhoud
- Cancer Center of Kansas, Dr. Mattar
- Kansas Nephrology, Rachel Reed, NP
- Wichita Anesthesiology, Kansas Pain Management, Dr. Ain & Sarah Kinderknecht, APRN
- Wichita Urology Group, Dr. Joudi & Shandi Husen, APRN
- Kansas Pathology Consultants
- Southcentral Pathology
- Dr. Thomas Ashcom
- Quest Diagnostics
- AEGIS
- Kingman Emergency Medical Services
- Plains Radiology Services
- United Radiology
- Bailey Medical Holdings
- LifeTeam Services
- Eagle Med Services
- Kingman Drug
- AMS Reference Lab
- Heartland Pathology

Updated: 12/30/2025

ADDENDUM B

Amounts Generally Billed (AGB)

KHC determines AGB by multiplying the gross charges for care provided to patients by the AGB% and then limiting the amount charged to not more than the resulting amount.

Example: Gross charges = $500, AGB percent is 55%, $500 x 55% = $275. The patient will not be charged more than $275 on the $500 billed.

KHC has elected to use the look back method in which the AGB % is calculated by dividing the total of all claims for Medicare fee for service and all private insurance during the prior 12-month period by the total gross charges for those claims. This AGB is based on data from the last fiscal year and will be updated annually.

Year	AGB%
2025	55%

Updated: 09/30/2025

ADDENDUM C

2025 Federal Poverty Levels (FPL)

Family Size	Percentage of Poverty Level 100%	Percentage of Poverty Level 125%	Percentage of Poverty Level 150%	Percentage of Poverty Level 175%	Percentage of Poverty Level 200%
1	$15,650.00	$19,562.50	$23,475.00	$27,387.50	$31,300.00
2	$21,150.00	$26,437.50	$31,725.00	$37,012.50	$42,300.00
3	$26,650.00	$33,312.50	$39,975.00	$46,637.50	$53,300.00
4	$32,150.00	$40,187.50	$48,225.00	$56,262.50	$64,300.00
5	$37,650.00	$47,062.50	$56,475.00	$65,887.50	$75,300.00
6	$43,150.00	$53,937.50	$64,725.00	$75,512.50	$86,300.00
7	$48,650.00	$60,812.50	$72,975.00	$85,137.50	$97,300.00
8	$54,150.00	$67,687.50	$81,225.00	$94,762.50	$108,300.00
Additional per person $5,140.00					

FINANCIAL ASSISTANCE DISCOUNTS

Annual Income is	Financial Assistance Discount
Below 100% of FPL	100%
101%-125%	85%
126%-150%	70%
151%-175%	55%
176%-200%	50%

Source: ASPE.HHS.GOV

ADDENDUM D

Kingman Healthcare Center
Application for Financial Assistance

(Check all applicable providers)

____KHC ____ Family Clinic ____ Cunningham Clinic

PATIENT INFORMATION: Name _____ Age/DOB _____

Address _____ City, State, Zip _____

Social Security # _____ Phone # _____

Martial Status: Married Single Divorced Widowed Legally Separated Life Partner

Number of dependents in home _____ Age of dependents _____

Employer Name _____ Address/Phone _____

Title/Position _____ Length of Employment _____

Secondary Employer _____ Address/Phone _____

RESPONSIBLE PARTY INFORMATION: ____ Check if same as patient

Name _____ Age/DOB _____

Address _____ City, State, Zip _____

Social Security # _____ Phone # _____

Martial Status: Married Single Divorced Widowed Legally Separated Life Partner

Number of dependents in home _____ Age of dependents _____

Employer Name _____ Address/Phone _____

Title/Position _____ Length of Employment _____

Secondary Employer _____ Address/Phone _____

SPOUSE INFORMATION:

Name _____ Age/DOB _____

Address _____ City, State, Zip _____

Social Security # _____ Phone # _____

Employer Name _____ Address/Phone _____

Title/Position _____ Length of employment _____

Secondary Employer _____ Address/Phone _____

FINANCIAL STATEMENT

GROSS MONTHLY INCOME: (documentation required)

Source	Self	Spouse	Dependent	Total
Employment Wages	$ _____	$_____	$_____	$_____
Self-Employment	$_____	$_____	$_____	$_____
Unemployment	$_____	$_____	$_____	$_____
Work Comp	$_____	$_____	$_____	$_____
Child Support	$_____	$_____	$_____	$_____
Alimony	$_____	$_____	$_____	$_____
ADC/Food Stamps	$_____	$_____	$_____	$_____
Social Security	$_____	$_____	$_____	$_____
Disability	$_____	$_____	$_____	$_____
Pensions/Retirement	$_____	$_____	$_____	$_____
Other Income	$_____	$_____	$_____	$_____

TOTAL $_____

ASSETS:
Residence: Own_____ Rent _____ (If Owned) Estimated Value $_____ Unpaid $_____
Real Estate: Business/Farm/Rental Property Estimated Value $_____ Unpaid $_____

VEHICLES:
#1 Make/Model/Year _____ Estimated Value $_____ Unpaid $_____
#2 Make/Model/Year _____ Estimated Value $_____ Unpaid $_____

FINANCIAL/BANKING:
Name _____ Account Type _____ Balance $_____

Name _____ Account Type _____ Balance $_____

OTHER ASSETS: (i.e., boats, motor homes, motorcycles, antiques) Value $_____

MONTHLY EXPENSES

Mortgage/Rent $_____	Vehicle Payment $_____	Prescriptions $_____
Groceries $_____	Vehicle Fuel $_____	Child Care $_____
Gas (heating) $_____	Vehicle Insurance $_____	Medical bills $_____
Electricity $_____	Life Insurance $_____	Child Support $_____
Water/Sewer/Garbage $_____	Medical Insurance $_____	Other $_____
Phone/cable/Internet $_____	Home/Renters Insurance $_____	Other $_____

LIABILITIES

Creditor Name	Original Balance	Current Balance	Monthly Payment

The following documentation must be provided for the application to be considered:

1. Copies of last 3 months paystubs for all employers. If self-employed, statement of 3 months income/expenses.
2. Unemployment and/or Work Comp benefits letter.
3. Proof of child support/Alimony income.
4. Most current complete bank statement (includes checking, savings, CD, money market).
5. Most recently completed tax return.
6. Social Security benefit letter verifying the benefit amount.
7. Letter of determination from Health and Human Services. You may apply online at www.kancare.ks.gov. Click on the "Check Eligibility" button and complete the questions. Print out the results page.
8. Support form. If another party is paying your expenses on your behalf, complete the attached statement.

If the application is incomplete, it will be returned. We will not be responsible for follow up on incomplete applications.

COMPLETED APPLICATIONS MUST BE RETURNED WITHIN 14 DAYS OF RECEIPT.

To consider an account for financial assistance, your medical condition at the time of service **MUST** be urgent or emergent.

COMMENTS:

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

CERTIFICATION:

I certify the information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services at Kingman Healthcare Center. I understand that all information provided is subject to verification. I hereby grant permission to Kingman Healthcare Center personnel to receive, release, or act upon financial information contained herein. I also release Kingman Healthcare Center and any party from liability from any acts, communications, or disclosures which are made pursuant to such an investigation. I understand that if the information which I submit is determined to be false, such a determination will result in a denial of the application and I will be liable for all charges.

Promissory Note: When after the Application for Financial Assistance is processed and it is determined that I am responsible for all or portion of the remaining balance identified in attachment to this application and upon receipt of the determination letter, I will accept responsibility for the amount identified, if applicable.

_____ _____

Signature (Patient/Guarantor) Date

_____ _____

Signature of Spouse Date

FOR OFFICE USE ONLY:

Process date: _____ Approval/Denial (circle) Expiration Date:_____

Approval % rate _____

KINGMAN HEALTHCARE CENTER
750 W. D AVE
KINGMAN, KS 67068

_____ KHC _____ Family Clinic _____ Cunningham Clinic

Patient Information Request Form

Patient Name: _____

Since patient listed above has no source of income, our office requires an explanation on how basic living expenses are paid for.

Please fill out the information requested and check the support item for living expenses that you provide for the patient listed above. Signing this form does not make you financially responsible for the bill.

Name of person providing support: _____

Relationship to patient: _____ List months provided: _____

[ ] Rent or housing.
[ ] Utilities for living expenses (electricity, water, gas, etc.)
[ ] Groceries/food/etc.
[ ] Personal care items such as: soap for laundry/showers, etc.
[ ] Transportation provided (such as vehicle rides/gas/etc.)
[ ] Other misc expenses (list) _____

I certify that I provide the support indicated above for this patient.

_____ _____
Signature of person providing financial support Date