KIT CARSON COUNTY HEALTH SERVICE DISTRICT
Application For Financial Assistance
Information Request

Date of Request: _____

Patient Name: _____ Account Number: _____

Responsible Party: _____ Phone Number: _____

Before we can complete the processing of your application, the following information, if checked, needs to be provided to Patient Financial Services.

_____ Most Recent W-2 form

_____ Paycheck stubs

_____ Most recent Federal Income Tax return

_____ Proof of residency in Kit Carson County (utility bill, tax bill)

_____ Written verification from public welfare agencies attesting to income status for the past twelve months

_____ Medicaid remittance voucher showing the patient's exhaustion of benefits for the current fiscal year or denial of coverage

_____ Completed Medicaid application or verification of ineligibility