Harrison County Community Hospital

# HCCH Medical Clinic Community Care Application

## PATIENT INFORMATION

| | |
|---|---|
| **Patient Name:**<br><br>**Phone:** | **Patient Address:** |
| **What county do you reside in?** | **Have you or your spouse ever served in the U.S. military?** ☐ Yes ☐ No |
| **Did you file federal income taxes last year?**<br>☐ Yes ☐ No | **Was the medical care the result of a crime?**<br>☐ Yes ☐ No<br>*If yes, date of crime* (mm/dd/yy): ____________<br>Describe the crime: |
| **Was the medical care the result of an accident?**<br>☐ Yes ☐ No<br>*If yes, accident date* (mm/dd/yy): ____________<br>Describe the accident: | **Check any of the following you receive:**<br>☐ Disability Income ☐ Medicare Benefits<br>☐ Other government aid (food assistance, etc.) |
| **Does anyone in your household operate their own business, or is anyone self-employed?**<br>☐ Yes ☐ No | |

**Please list all individuals living in the household.**

| Name (Last, First, MI) | Age | Relationship |
|---|---|---|
| | | |
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**APPLICATION IS FOR MEDICAL CLINIC SERVICES ONLY.**

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## HOUSEHOLD INCOME

| Monthly Income | Patient | Other Responsible Party |
|---|---|---|
| Gross Wages (including tips, overtime) | | |
| Social Security | | |
| Supplemental Security Income (SSI) | | |
| Social Security Disability | | |
| Trust Funds or Annuities | | |
| Pension or Retirement | | |
| Interest or Dividends | | |
| Veteran's Benefits | | |
| Unemployment Compensation | | |
| Rental Income | | |
| Alimony or Child Support | | |
| State Assistance | | |
| Food Stamps | | |
| Other | | |
| **TOTAL** | | |

## HEALTH INSURANCE COVERAGE

**(Completing this section is optional. Responses will not impact eligibility.)**

**Do you currently have health insurance?**
☐ Yes ☐ No
*If yes, coverage type:* ☐ Medicaid ☐ Disability
☐ Medicare ☐ Tricare ☐ Commercial
☐ MC+ or Managed Plan with Mo HealthNet

**Do you have other insurance coverage, such as AFLAC, that helps pay medical expenses?**
☐ Yes ☐ No

**Have you applied for Social Security Disability?**
☐ Yes ☐ No
*If yes, application date* (mm/dd/yy): ______________
*Status:* ☐ Pending ☐ Appeal ☐ Rejected
*If your application was rejected, how long ago did you apply?* ☐ 1 yr. ☐ 2 yrs. ☐ 3+ yrs.

**Has anyone in your household applied for MO HealthNet or Medicaid?**
☐ Self ☐ Spouse ☐ Children If yes, when (mm/dd/yy)? ________________

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**Community Care Application**

## COMMUNITY CARE APPLICATION CHECKLIST

**To apply for Community Care from the Harrison County Community Hospital District, your request must include all items listed below. Your application will not be processed until all items are received.**

- ☐ Application for Community Care
- ☐ Patient Agreement form (signed)
- ☐ Federal income tax return
- ☐ Two of your most recent paycheck stub(s)
- ☐ Proof of all other income sources
- ☐ Self-Employed individuals will be required to submit details of the most recent 3 months of income/expenses for the business

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## HCCH Medical Clinic
## Community Care Application

### Patient Agreement

The undersigned applies for financial assistance indicated in this application and represents that all statements made in this application are true and are made for the purpose of obtaining Community Care. The undersigned authorized the release of necessary medical and financial information to obtain third-party coverage. The original or a copy of this application will be retained by Harrison Community Hospital District (HCCH) even if the financial assistance is not granted. The undersigned also agrees to allow HCCH to contact any or all of the above references for credit verification. Falsification of information on this application is grounds for disapproval.

**The undersigned understands that if HCCH is unable to process the application because all required documents have not been provided, then:**

- payment will be expected for the care provided.
- a letter will be sent stating the request for Community Care is denied. Once HCCH receives the required documents, the application will be re-processed.

**The undersigned will receive billing statements on the current balance until the application is processed.**

- If the application is approved for full assistance, it will be based on the current balance. If the application is not approved for full assistance, then prompt payment is expected. A payment plan can be set up if a patient is unable to pay bills in full.

**The undersigned has been informed that unpaid hospital or medical clinic bills will be sent to a collection agency after 120 days. Failure to pay your agreed to amount may result in loss of all previously approved financial assistance.**

______________________________ ______________________
Patient Signature Date

______________________________ ______________________
Responsible Party or Spouse Signature Date

### Mail the Community Care Application to:

Patient Accounts, Harrison County Community Hospital, 2600 Miller St., Bethany, MO 64424

# Harrison County Community Hospital

## Community Care Application

**Patient Name** ______________________________

**Account Number (s)**: ______________________________

**2026 Poverty Guidelines:**

| Persons in Family/Household | 100% Poverty | 110% Poverty | 120% Poverty | 130% Poverty | 140% Poverty | 150% Poverty | 160% Poverty | 170% Poverty | 180% Poverty | 190% Poverty | 200% Poverty | >200% Poverty |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1** | $15,960 | $17,556 | $19,152 | $20,748 | $22,344 | $23,940 | $25,536 | $27,132 | $28,728 | $30,324 | $31,920 | $31,300 + |
| **2** | $21,640 | $23,804 | $25,968 | $28,132 | $30,296 | $32,460 | $34,624 | $36,788 | $38,952 | $41,116 | $43,280 | $42,300 + |
| **3** | $27,320 | $30,052 | $32,784 | $35,516 | $38,248 | $40,980 | $43,712 | $46,444 | $49,176 | $51,908 | $54,640 | $53,300 + |
| **4** | $33,000 | $36,300 | $39,600 | $42,900 | $46,200 | $49,500 | $52,800 | $56,100 | $59,400 | $62,700 | $66,000 | $64,300 + |
| **5** | $38,680 | $42,548 | $46,416 | $50,284 | $54,152 | $58,020 | $61,888 | $65,756 | $69,624 | $73,492 | $77,360 | $75,300 + |
| **6** | $44,360 | $48,796 | $53,232 | $57,668 | $62,104 | $66,540 | $70,976 | $75,412 | $79,848 | $84,284 | $88,720 | $86,300 + |
| **7** | $50,040 | $55,044 | $60,048 | $65,052 | $70,056 | $75,060 | $80,064 | $85,068 | $90,072 | $95,076 | $100,080 | $97300 + |
| **8** | $55,720 | $61,292 | $66,864 | $72,436 | $78,008 | $83,580 | $89,152 | $94,724 | $100,296 | $105,868 | $111,440 | $108,300 + |
| **DISCOUNT** | **100%** | **90%** | **80%** | **70%** | **60%** | **50%** | **40%** | **30%** | **20%** | **15%** | **10%** | **0%** |

**2026 Poverty Guidelines**

For families/households with more than 8 persons, add $5,680 for each additional person.

**Notes**

☐ The applicant is eligible for Community Care of ___________ %

**Amount of discount** $_______________

☐ The applicant is not eligible for a Community Care Discount

**Self Pay Patients**

**Patient approved for Medicaid**

___________ Approval date

**Patient has pending Medicaid application**

___________ Date of Medicaid application

☐ Proof of Medicaid application submission

**Medicaid denied**

___________ Date of denial

☐ Proof of Medicaid denial attached

______________________________ Authorized HCCH Signature

______________________ Date