



PATIENT INFORMATION

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

Please list all individuals living in the household.

Name (Last, First, MI)	Age	Relationship



HOUSEHOLD INCOME

Monthly Income	Patient	Other Responsible Party
GrossWages (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		
Subtotal		
TOTAL		

FINANCIAL ASSETS
MEDICAL CLINIC ACCOUNTS EXCLUDED

	Self	Spouse	Joint	Bank/Firm Name	Balance/Value
Checking Acct.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Savings Acct.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Certificatesof Deposit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
IRAs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
401(K)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stocks/Bonds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Mutual Funds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Health Savings Acct.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Cash Value Life Ins.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		



HEALTH INSURANCE COVERAGE
For Accounts at the Hospital

<p>Do you currently have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, coverage type:</i> <input type="checkbox"/> Medicaid <input type="checkbox"/> Disability <input type="checkbox"/> Medicare <input type="checkbox"/> Tricare <input type="checkbox"/> Commercial <input type="checkbox"/> MC+ or Managed Plan with Mo HealthNet</p>	<p>Do you have other insurance coverage, such as AFLAC, that helps pay medical expenses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Have you applied for Social Security Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, application date (mm/dd/yy):</i> _____ <i>Status:</i> <input type="checkbox"/> Pending <input type="checkbox"/> Appeal <input type="checkbox"/> Rejected <i>If your application was rejected, how long ago did you apply?</i> <input type="checkbox"/> 1 yr. <input type="checkbox"/> 2 yrs. <input type="checkbox"/> 3+ yrs.</p>	<p>Has anyone in your household applied for MO HealthNet or Medicaid? <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children <i>If yes,</i> <i>when (mm/dd/yy)?</i> _____</p>

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

For accounts at the Hospital (for services completed within the hospital) we will need the following additional documentation.

- Past three months' bank statements (checking, savings, etc.)
- Past three months investment account statements (IRAs, stocks, bond, etc.)
- Most recent property tax receipt(s)

Copy of Medicaid Application Denial (for self-pay patients only)



**Harrison County
Community Hospital**

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 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



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	\$97,300 +
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