Salina Regional Health Center (SRHC) affirms and maintains its commitment to serve our community regardless of age, race, color, religion, sex, national origin, disability, veteran status, gender identification and whether they are uninsured or underinsured. In furtherance of these principles, SRHC provides financial assistance for certain individuals who receive emergency or other medically necessary care. Confidentiality of information will be maintained for all who seek financial assistance at SRHC.

Checklist for Financial Assistance

Please complete the two page application in full and attach the requested proof of income. The following documents must accompany your application in order for it to be considered. Documentation from all adults in the household, age 18 and older, who are no longer in high school, must be provided. SRHC reserves the right to request additional documentation as determined by administration.

Income Tax Return – Complete Federal Income Tax Return, with preparer's signature. All schedules that were completed must be provided. (IE: Schedule E for rental income).

Salary/Wages – Copies of pay stubs from the most recent three months from each employer. Pay stubs must show gross wages.

Child Support / Alimony – Proof of any support received at any time during the last 12 months. Please provide a 1 year payment history from the Kansas Payment Center.
If you are a foster parent, please provide child placement documents showing compensation for the child(ren) in your care.

Government Assistance – A current Social Security benefit letter; SSI Disability letter; proof of Veteran's benefits; pension/retirement income; unemployment; worker's compensation; or any other government subsidy benefits.

Public Assistance / DCF – Proof of food stamps; cash, housing, utility and/or child care assistance.

Student Scholarships/Grants – Copies of documentation showing monies received for grants and scholarships for the last 12 months. A current class schedule or proof of enrollment for any post-secondary student (college, junior college, trade or technical school, etc).

Other sources of income – Rental income, monetary gifts, gambling winnings, etc.

If you have any questions while filling out the application, please contact Customer Service.

SRHC Customer Service
217 S Santa Fe Ave
Salina, KS 6740
P: (785) 452-6299
F: (785) 452-6110

Salina Regional Health Center
400 S Santa Fe Ave
PO Box 5080
Salina KS 67401
(785) 452-7000

Complete this application and send to Salina Regional Health Center, PO Box 5080, Salina KS 67402.
******Your application will not be accepted if there is incomplete or missing information.******

DATE OF APPLICATION:

Have you applied for SRHC's Finanacial Assistance in the last 6 months?

If so, what was the approximate date of the application?

Applicant Information		
Name		
Date of Birth		
Address		
City	State	Zip
Phone #		
Marital Status		
Employer & Hire Date		

Spouse / Significant Other Information		
Name		
Date of Birth		
Address		
City	State	Zip
Phone #		
Marital Status		
Employer & Hire Date		

Additional Occupants of the Household			If occupant is over 18 years old:
Name	Date of Birth	Relationship	Employer & Hire Date

Income Verification: Please provide the previous three months of paycheck stubs and current tax return, etc.				
(provide proof of income)	Name of person(s) receiving income	Amount	How often is income received?	**FOR CUSTOMER SERVICE USE ONLY**
Salary/Wages				
Child Support and/or Alimony				
SSI/SSDI Benefits				
Veterans Benefits				
Unemployment				
Worker's Compensation				
Pension/Retirement Income				
Public Assistance /DCF: Food stamps, Housing, Utility, Child care or Cash assistance				
Scholarships/Grants for school				
Rental Income				
Other Income/Assistance:				

Household Expenses: Please list expenses for all occupants of the household. Be as complete as possible.		
Type of expense	Monthly payment	Who do you pay?
Rent / Mortgage		
Electricity		
Gas		
Water / Trash		
Phone / Internet		
Cable TV		
Home Insurance		
Food estimate		
Child Care		
Car Loan		
Car Insurance		
Gas		
Health Insurance		
Life Insurance		
Prescriptions Medications		
Credit card(s)		
Other Expense		
TOTAL EXPENSES		

I hereby request that Salina Regional Health Center make a written determination of my eligibility for financial assistance. I certify that the above information is true and correct. I understand that the information I submit concerning my income, expenses and family size is subject to verification by Salina Regional Health Center and I hereby authorize them to do so. I further authorize the employers/institutions to release such information. I also understand that if the information I submit is determined to be false, such a determination will result in denial of finanacial assistance, and that I will be liable for charges of services provided.

Signature **Date**