CENTRAL CARE CANCER CENTER

Heartland Cancer Center
410 E Spruce St, Garden City, KS 67846
620-272-2579 f: 620-272-2685

HEARTLAND ONCOLOGY, LLC

PLEASE CIRCLE COMPANY

Hardship:_____ **Patient:**_____ **Approved by:**_____

Financial Hardship Application

Applicant's Name _____
Address _____ City _____ State _____
Telephone No. _____ SSN _____ DOB _____ Zip _____

Patient's Name _____ Acct No _____
Address _____ City _____ State _____
Telephone No. _____ SSN _____ DOB _____ Zip _____

Employer _____ Position _____ How Long? _____
Address _____ City _____
Telephone No. _____ State/Zip _____

Spouse's Name _____ SSN _____ DOB _____
Spouse's Employer _____ Position _____
Address _____ How Long? _____
Telephone No. _____ City _____ State _____ Zip _____

Number of Family Members _____ ***(list name and relationship)***

(Including you, your spouse, your children, and any one residing with you that you support. Also students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption are considered to be residing with those who support them.)

Have you applied for Government Assistance:_____ **(If no, why not?)**_____

Do you have a Cancer Policy: _____

CENTRAL CARE CANCER CENTER

Heartland Cancer Center
410 E Spruce St, Garden City, KS 67846
620-272-2579 f: 620-272-2685

HEARTLAND ONCOLOGY, LLC

Financial Hardship Application

Income: List income for your family from: (as applicable)

	Gross Income Last 3 Months	Gross Income Last 12 Months
Wages		
Public & Emergency Assistance		
Social Security		
Unemployment Compensation		
Worker's compensation		
Farm or Self Employment		
Strike Benefits		
Alimony		
Child support		
Military Family Allotments		
Pensions		
Income from Dividends, Interest		
Rental Property		
Other		
Total:		

Note:
Please try to be as detailed as you can when noting income and expenses.
Include some type of proof of income (copies of check stubs, W-2 forms, Income Tax return, etc.) ***Hardship application will be returned as unprocessable if the income documentation is not included with the application.***

CENTRAL CARE CANCER CENTER

Heartland Cancer Center
410 E Spruce St, Garden City, KS 67846
620-272-2579 f: 620-272-2685

HEARTLAND ONCOLOGY, LLC

Financial Hardship Application

Expenses: List all payments you make monthly and approximate amount(s) left owing. Be as specific and complete as possible.

	Who do You Pay?	Monthly Payment	Balance
Rent/House Payment			
Electric/Gas			
Water			
Telephone			
Cable TV			
Food Estimate			
Car Loan			
Car Insurance			
Gas			
Credit Cards:			
Health Insurance			
Life Insurance			
Prescription Medicines			
Child Care			
Other			
Total			

CENTRAL CARE CANCER CENTER

Heartland Cancer Center
410 E Spruce St, Garden City, KS 67846
620-272-2579 f: 620-272-2685

HEARTLAND ONCOLOGY, LLC

Financial Hardship Application

I hereby request that Central Care, PA/Heartland Oncology, LLC make a written determination of my eligibility for financial assistance. I certify 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 Central Care, PA/Heartland Oncology, LLC and 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 providing financial assistance, and that I will be liable for charges of services provided. As is consistent with HIPAA regulations, all of my personal information will be kept private and secure by Central Care PA/Heartland Oncology,

_____ _____
Signature Date

_____ _____
Witness Date

This document was received on the _____ day of _____, _____

by _____