HCCH Medical Clinic
Community Care Application

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?** ❑ Yes ❑ No
Did you file federal income taxes last year? ❑ Yes ❑ No	**Was the medical care the result of a crime?** ❑ Yes ❑ No *If yes, date of crime* (mm/dd/yy): _____ Describe the crime:
Was the medical care the result of an accident? ❑ Yes ❑ No *If yes, accident date* (mm/dd/yy): _____ Describe the accident:	**Check any of the following you receive:** ❑ Disability Income ❑ Medicare Benefits ❑ Other government aid (food assistance, etc.)
Does anyone in your household operate their own business, or is anyone self-employed? ❑ Yes ❑ No	

Please list all individuals living in the household.

Name (Last, First, MI)	Age	Relationship

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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)? _____

APPLICATION IS FOR MEDICAL CLINIC SERVICES ONLY.

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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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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

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2025 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	$15,650	$17,215	$18,780	$20,345	$21,910	$23,475	$25,040	$26,605	$28,170	$29,735	$31,300	$31,300 +
2	$21,150	$23,265	$25,380	$27,495	$29,610	$31,725	$33,840	$35,955	$38,070	$40,185	$42,300	$42,300 +
3	$26,650	$29,315	$31,980	$34,645	$37,310	$39,975	$42,640	$45,305	$47,970	$50,635	$53,300	$53,300 +
4	$32,150	$35,365	$38,580	$41,795	$45,010	$48,225	$51,440	$54,655	$57,870	$61,085	$64,300	$64,300 +
5	$37,650	$41,415	$45,180	$48,945	$52,710	$56,475	$60,240	$64,005	$67,770	$71,535	$75,300	$75,300 +
6	$43,150	$47,465	$51,780	$56,095	$60,410	$64,725	$69,040	$73,355	$77,670	$81,985	$86,300	$86,300 +
7	$48,650	$53,515	$58,380	$63,245	$68,110	$72,975	$77,840	$82,705	$87,570	$92,435	$97,300	$97300 +
8	$54,150	$59,565	$64,980	$70,395	$75,810	$81,225	$86,640	$92,055	$97,470	$102,885	$108,300	$108,300 +
DISCOUNT	**100%**	**90%**	**80%**	**70%**	**60%**	**50%**	**40%**	**30%**	**20%**	**15%**	**10%**	**0%**

2025 Poverty Guidelines