

Application for Sponsored Care

Please fill out the attached "Personal Financial Statement for Financial Assistance" attached.

Copies of the following items must accompany the application:

- a) Copy of all earning statements (pay stubs) for the last three (3) months.
- b) Copy of all banking and savings account statements for the last three (3) months.
- c) Copy of the most recent Federal Tax Return.
- d) Personal Financial Statement
- e) Medicaid Acceptance/Denial Letter

Applicants Signature _____

Date _____

Medicaid Status _____ (Copy of denial letter must be attached)

Please return application and documentation to:

Sheridan County Health Complex
Business Office
826 18th Street - Box 167
Hoxie KS 67740

Finance Service Area

Date Received _____

Application Reviewed By _____

Information Received:

- _____ Copy of all earning statements (pay stubs) for the last three (3) months.
- _____ Copy of all banking and saving account statements for the last three (3) months.
- _____ Copy of the most recent Federal Tax Return.
- _____ Copy of SRS Denial Letter Status: _____
- _____ Other _____

Sponsorship Determined: Full - Partial - Pending - Denied (circle one)

Sponsored Care Worksheet Completed [] Yes [] No

Acknowledgement Returned to Applicant _____ (Date/Initials)

