All accounts are due and payable within 30 days of the first 'balance due' statement date. If payment in full or payment arrangements have not been made within 30 days of the statement date, your account will be delinquent and may be sent to a collection agency.

If you are experiencing financial hardship, you may qualify for financial assistance. Please make an appointment with the Financial Service's Assistant at our facility for assistance in completing a Financial Assistance Application.

The Rawlins County Health Center Financial Assistance Program (FAP) exists to provide eligible patients partially or fully discounted emergent or medically necessary hospital care. **Patients seeking Financial Assistance must apply for the program**. Please see below.

Eligible Services – Emergent and/or medically necessary healthcare services provided by Rawlins County Health Center.
Eligible Patients – Patients receiving eligible services, who submit a Financial Assistance Application (including related documentation/information), and who are determined eligible for Financial Assistance by Rawlins County Health Center.

How To Apply – Financial Assistance Application may be obtained/completed/submitted as follows:

- From the Rawlins County Health Center's admissions desk or Financial Service's Assistant.
- By calling 785-626-3211 Ext. 203.
- By mail at Rawlins County Health Center, 707 Grant St, Atwood, KS 67730.
- Download an application through the Rawlins County Health Center Website: (www.rchc.us).

Determination of Financial Assistance Eligibility - Generally, patients are eligible for financial assistance based on their income level and assets (See Appendix A of the Financial Assistance Application link at (www.rchc.us). Eligible patients will not be charged more for emergency or other medically necessary care than Amounts Generally Billed (AGB) to those patients who have insurance.

IF ANY OF THE FOLLOWING INFORMATION HAS CHANGED SINCE YOUR LAST STATEMENT, PLEASE INDICATE BELOW	
ABOUT YOU:	**ABOUT YOUR INSURANCE:**
YOUR NAME (Last, First, Middle Initial)	PRIMARY INSURANCE COMPANY'S NAME: EFFECTIVE DATE
ADDRESS:	PRIMARY INSURANCE COMPANY'S ADDRESS:
CITY STATE ZIP	CITY STATE ZIP
TELEPHONE:	POLICYHOLDER'S ID # GROUP PLAN #
EMPLOYER'S NAME	SECONDARY INSURANCE COMPANY'S NAME: EFFECTIVE DATE
EMPLOYER'S ADDRESS CITY STATE ZIP TELEPHONE	SECONDARY INSURANCE COMPANY'S ADDRESS: CITY STATE ZIP
	POLICYHOLDER'S ID# GROUP PLAN #