

Charitable Health Care Provider Agreement

License or Registration Number: _____ Profession (MD, RN, DDS, etc.): _____

Name: _____ Date of Birth: ____/____/____
First MI Last

Address: _____ County: _____
Street Address
City State Zip Phone Number: _____

Email Address: _____ Fax Number: _____

My signature on this agreement constitutes my intention to provide care to medically indigent patients. I understand that in order to be considered gratuitous, I may not charge the patient or individually submit a claim for those patients with public or private insurance. I understand that if I provide charitable care through an indigent health care clinic or local health department, they may charge uninsured patients a reasonable fee based on patients' ability to pay (sliding scale), may submit claims to public or private insurance, and I may receive a fee for my services from the indigent health care clinic or local health department.

Nothing in this agreement waives my right to bill insurance or an individual patient for services provided when that care is not provided as part of my participation in the Charitable Health Care Provider Program.

I understand it is my responsibility to maintain patient records for services I provide as a Charitable Health Care Provider and that either I or the indigent health care clinic or local health department through which I will provide care must:

- (1) determine that individuals seen as part of my participation in the charitable health care provider program are medically indigent; and
- (2) submit an annual activity report to KDHE.

I agree that failure to fulfill any of these duties will result in cancellation of the agreement by the Secretary of the Kansas Department of Health and Environment to serve as a charitable health care provider.

Signature of Provider _____ Date _____

I will be providing care through the following indigent health care clinic or health department, which will provide an annual report of the charity care I have provided. _____
Name of indigent health care clinic or health department

I will be providing care independently and will report my activities annually on Form C.

Please send a copy of my letter of agreement to the following indigent health care clinic or health department:

Name and address of indigent health care clinic or health department

If a charitable provider is sued by the recipient of his or her charitable care, they must request representation from the state in writing within 15 days after service of process or subpoena (KSA 75-6108(e)). Charitable providers served with a summons or petition should immediately contact the Kansas Attorney General's office at 785-296-2215.

Please return to:
Charitable Health Care Provider Program
Kansas Department of Health and Environment
Bureau of Community Health Systems
1000 SW Jackson, Suite 340
Topeka, KS 66612

Phone: 785-296-3135
Fax: 785-296-1231