APPLICATION FOR FINANCIAL ASSISTANCE

PERSONAL INFORMATION:

Patient Name: _____ Birth Date_____

Address: _____ Phone: _____

_____ Cell: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed

Spouse Name: _____ Birth Date_____

Address: _____ Phone: _____

_____ Cell: _____

DEPENDENTS:

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

PATIENT EMPLOYER:

Name: _____

Address: _____

Phone: _____

How long employed? _____

___Full Time ___Part Time

Health Insurance? ___Yes ___No

Retirement Plan? ___Yes ___No

Monthly Gross Wages: $_____

If not currently employed, last date of employment: _____

SPOUSE EMPLOYER:

Name: _____

Address: _____

Phone: _____

How long employed? _____

___Full Time ___Part Time

Health Insurance? ___Yes ___No

Retirement Plan? ___Yes ___No

Monthly Gross Wages: $_____

If not currently employed, last date of employment: _____

REPORTED INCOME: (WAGES, ALIMONY, CHILD SUPPORT, DISABILITY, SOCIAL SECURITY, PENSION, ETC.)

Patient: ____ YES _____ NO If yes, income per month $_____ and Source_____

Spouse: ____ YES _____ NO If yes, income per month $_____ and Source_____

Do you receive food stamps, utility, or housing assistance? ____Yes ____No Amount $_____

Have you filed for Bankruptcy? ____Yes ____No Case #_____

IF YOU REPORT ZERO INCOME, PLEASE SUBMIT A SIGNED STATEMENT EXPLAINING HOW YOUR DAILY LIVING EXPENSES ARE BEING COVERED AND BY WHOM.

Personal/Business Assets:

Checking Accts $: _____ Savings Accts $: _____

Retirement Accts $: _____ HSA Accts $: _____

Investments $: _____ CD's $:_____

Cash Value Life Ins $: _____ Other $: _____

APPLICATION FOR FINANCIAL ASSISTANCE – *FARMER, RANCHER, BUSINESS OWNER*

Values are as of what date?:_____ Name of Business: _____

***BUSINESS* ASSETS:**

Cash$:_____ at actual balance

Investments$:_____ at actual balance

Accounts Receivable$:_____ at actual balance

Inventory$:_____ at cost

Stored crops$:_____ at market value

Livestock$:_____ at market value

Land/other RE$:_____ at market value

Equipment$:_____ at market value

Vehicles$:_____ at market value

Other assets$:_____ describe: _____

Other assets$:_____ describe: _____

Total Assets $:_____

***BUSINESS* LIABILITIES:**

Loan Payable$:_____ describe: _____

Loan Payable$:_____ describe: _____

Loan Payable$:_____ describe: _____

Credit Card Payable$:_____ describe: _____

Credit Card Payable$:_____ describe: _____

Accounts Payable$:_____ Salaries Payable$:_____

Payroll Taxes Payable $:_____ RE Taxes Due$:_____

Other Liabilities $:_____ Other Liabilities $:_____

Total Liabilities$:_____ Net Worth$:_____

****You may substitute a current Financial Statement prepared by your bank or accountant****

APPLICATION FOR FINANCIAL ASSISTANCE – SUPPORTING DOCUMENTATION

INCLUDE THE FOLLOWING INFORMATION. WITHOUT THIS DOCUMENTATION, YOUR APPLICATION WILL BE DENIED.

- Paycheck stubs – 60 days from employer, unemployment, or worker's compensation **for *all adult members of your household***.
- Current and complete bank, credit union, investment account statements, and life insurance cash surrender value statements for the last ***THREE*** months.
  - Checking Pension/Retirement Stock/Bonds
  - Savings IRS/401K/403B Life Insurance
  - CD's Annuities
- Complete Tax Return for current year
- Proof of Medicaid Denial (Nebraska Medicaid determination letter)
  - www.accessnebraska.ne.gov or 855-632-7633.
- Documentation of any additional income received by any member of the household
  - Social Security ADC/WIC Pension/Retirement/Annuity
  - Alimony/Child Support VA benefits Housing/Utility assistance
  - Disability College grants/scholarships Other

APPLICATION FOR ASSISTANCE ATTESTATION

I hereby submit this information for the purpose of allowing Box Butte General Hospital to evaluate my financial status to determine my eligibility for various financial assistance programs. I authorize BBGH to verify this information, employment and/or income verification and appropriate supporting documents.

I attest that the information and all documentation provided are complete and accurate as shown. I realize that should any of this information prove to be false, all financial assistance will be denied, and I will accept responsibility for full and immediate payment of any and all outstanding balances.

By applying for financial assistance, I also agree to accept payment responsibility for any amount due from me as a result of any financial assistance which may be awarded.

I authorize BBGH to contact me using any of the following methods:

Patient	Spouse
☐ Home telephone: _____	☐ Home telephone: _____
☐ Work telephone: _____	☐ Work telephone: _____
☐ Cell phone: _____	☐ Cell phone: _____

Signature of Patient: _____ **Date: _____**

Signature of Spouse: _____ **Date: _____**