Nebraska Medicine

SERIOUS MEDICINE. EXTRAORDINARY CARE.®

Guarantor Name
Address
City, State, Zip

Date: Today's Date

Name (First, Middle, Last)	**Responsible Party ID #:**	**Return By:**

Nebraska Medicine is committed to providing medical care to those patients who may not have sufficient financial resources available. If you qualify for assistance, a portion of your account(s), up to 100%, may be forgiven. You will not be responsible for the amount that is forgiven. Nebraska Medicine administers this assistance program in a manner that does not discriminate based on race, creed, color, sex, national origin, religion, or age.

Instructions: Complete application in its entirety. Application must include copies of any of the following documents that apply to you. Please attach copies and not originals, as Nebraska Medicine cannot guarantee the return of documents sent with the application. **If any of the documents are missing, it will delay processing of your application and/or may result in Denial of the application leaving you responsible for the entire balance.**

Mail the completed Application and documents to:

Nebraska Medicine
Attn: Patient Access – Financial Counseling
97530 Nebraska Medical Center
Omaha, NE 68198-7530

1. **If You Have Income:**
   - ☐ Attach a copy of your most recent IRS Form 1040 and appropriate schedules

   If you did not file a federal income tax return you must:
   - ☐ State in writing that you are not required to file and the reason why (send this with application)
   - ☐ Send us a copy of the most recent federal income tax return of anyone who claimed you as a dependent

   Attach Additional proof of your household income, which may include:
   - ☐ Social Security 1099 forms or award letters
   - ☐ Unemployment or workers' compensation award letters
   - ☐ Last two pay stubs (self, spouse and others residing in the same household)
   - ☐ If you are self-employed, you must include a Schedule C and/or profit and loss statement
   - ☐ Child Support or Alimony
   - ☐ Snap (Food Stamps), Heating or Housing assistance letters
2. **If you have No Income:**
   - ☐ If you have no income, send us a letter of support. The person who provides your support must sign the letter and have document notarized.
3. **Proof of Household Cash Available**
   - ☐ Checking and/or savings accounts
   - ☐ Stocks, bonds, certificates of deposit (CDs), high yielding interest accounts, or annuities
   - ☐ Any other investments, including real estate
   - ☐ Health Savings Accounts (HSA), Medical Saving Accounts (MSA, Flexible Spending Arrangements (FSA), or Health Reimbursement Arrangements (HRA)
4. **Letter of Denial of Medical Assistance**
   - ☐ Based on initial financial screening, you may need to apply for Medical Assistance (Medicaid, Disability and/or other available programs) and send a copy of your Letter of Denial before we can approve your application. Although financial assistance may be approved for services, you may be required to complete Medical Assistance applications at any time during the process.

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Name (First, Middle, Last)	Responsible Party ID #:	Return By:

FINANCIAL ASSISTANCE APPLICATION FORM

Name of Responsible Party:

Address: **City:** **State:** **Zip:**

Daytime Phone Number: **Household Size (Patient, Spouse and Dependents):** **Marital Status:**

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student **Employers Name:**

Employment Length: **Unemployed Date/Length**: (Month, DD, YYYY)

Name of Spouse/Partner:

Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐Unemployed ☐Student **Employers Name:**

Employment Length: **Unemployed Date/Length** (Month, DD, YYYY)

Dependents (If more than 5 dependents use a separate page)

	Full Name	Relationship	Birth Date (Month, DD, YYYY)
1.			
2.			
3.			
4.			
5.			

Do you have health Insurance? ……. ☐**Yes** ☐**No**

If **YES** please enclose a front and back copy of your insurance card(s).

Did you apply for Medicaid/Disability or other government assistance in last 6 months? …… ☐**Yes** ☐**No**

If **YES** please enclose a copy of the Letter of Denial or proof of eligibility.

Services related to an auto accident, Worker's Compensation, or any third party litigation please provide attorney and/or representative's name and contact information:

Name:
Address:
Phone Number:
Type of Case:

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your IRS Form 1040 and other proof of income documents (see documentation checklist).

	Self	Spouse and/or other household members		Self	Spouse and/or other household members
Wages	$	$	**Unemployment**	$	$
Self Employment	$	$	**Workers Compensation**	$	$
Pension or Retirement	$	$	**Alimony**	$	$

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Dividends or Interest	$	$	**Child Support**	$	$
Rents and Royalties	$	$	**Other**	$	$

Monthly House hold and Medical Expenses: Write N/A for any items that do not pertain to you. Use another sheet for additional					
	Unpaid Balance	**Monthly Payment**		**Unpaid Balance**	**Monthly Payment**
Mortgage	$	$	**Collection Agencies**	$	$
Rent	$	$	**Credit Cards**	$ $	$ $
Loans	$ $	$ $	**Utilities**	$ $	$ $
Medical Expenses	$ $	$ $	**Food**	$	$
Prescription Drugs	$	$	**Auto Insurance**	$	$
Child Care	$	$	**Life Insurance**	$	$
Telephone	$ $	$ $	**Health Insurance**	$	$
Other	$				

Available Household Resources: Attach copies of your household statements for the last month to this application.
Do you or other members of your household have a bank account? ..... ☐Yes ☐No
If **YES,** please enclose the most recent monthly statement. Check the types of accounts you have:
☐Checking ☐Savings ☐Money Markets ☐Certificates of Deposit (CD's) ☐Health Savings Accounts (HSA, FSA, MSA, HRA)

Do you have any stocks, bonds, or other investments? ..... ☐Yes ☐No
If **YES,** please enclose copies of the most recent statements.

Motor Vehicle: ☐Own ☐Lease (check one) **Make** **Model** **Year**
Make **Model** **Year**

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services, which are rendered to me by Nebraska Medicine. I hereby grant permission to Nebraska Medicine personnel authorized to receive, release, or act upon financial information, to investigate the information contained herein. Investigate shall include the contacting, by written communication or telephone, of those persons, firms, corporations, etc. noted by you on this financial information document. Investigation may also include a credit check. I hereby release the designated hospital personnel and all parties who supply information at the request of the hospital personnel from liability for any acts of commission or omission, communications or disclosures that are made pursuant to such an investigation. I understand that submission of false information will automatically disqualify me for any type of assistance.

Responsible Party Signature_____ Date: _____

Spouse Signature_____ Date: _____