FINANCIAL ASSISTANCE APPLICATION

Nemaha County Hospital has developed an option to ensure a fair and comprehensive system of providing financial assistance to those with special needs. Eligibility is determined by income level based on the current poverty guidelines established by the Department of Health and Human Services that are published in the Federal Register. Nemaha County Hospital expands the eligible income level up to 150% of the current poverty guidelines in order to provide assistance to patients in need. For qualifying individuals, the amount of financial assistance will be provided for 100% of the billed charges for a 6 month time frame from the date of application approval. All services offered by Nemaha County Hospital will be eligible for Financial Assistance. Please review this application and call our Financial Services Representative for further information at 402-274-4366, ext. 6459.

To determine the eligibility for financial assistance you need to complete and return this form.
We will also need the following additional information before reviewing your application:

- -A completed Nemaha County Hospital Financial Statement
- -Verification of income(W2's, Most recent tax returns or 3 months of paycheck stubs)
- -Application to Social Services for medical assistance when applicable

FAILURE TO PROVIDE ALL OF THE REQUESTED INFORMATION COULD RESULT IN DENIAL OF APPLICATION

Name of Person Applying for Financial Assistance : ______________________________

Spouse Name : ______________________________

Address : ______________________________ Phone : ______________

Dependents' Names : ______________________________

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc). which may be available for payment of my hospital/outreach clinic charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by Nemaha County Hospital. I hereby grant permission to Nemaha County Hospital to investigate the information contained therein.

Signature : ______________________________ Date: ________

*******THIS BOX TO BE USED FOR NCH STAFF VERIFICATION*******

Date Given to Patient/Guarantor : ______________ Date NCH received completed info: ______________

Verification of Documents : F/S __ SS __ Income __________

The information has been verified and the applicant is: Approved Denied

Type of Financial Assistance Approved for: Financial Medical

Condition/Reason for denial : ______________________________

Financial assistance to be provided at a reduction of 100% for dates of service ______ to ________ .

Applicant Notified : _______________	Approved by : ____

Form-120PF3001 Rev. 11/15, 1/16