NEMAHA COUNTY
HOSPITAL

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 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 : _____

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NEMAHA COUNTY
HOSPITAL

NEMAHA COUNTY HOSPITAL FINANCIAL STATEMENT

PATIENT INFORMATION

Name : _____ SS #(optional) : _____

Address : _____

Phone # : _____

RESPONSIBLE PARTY

Name : _____

Employer : _____

Address : _____

Phone # : _____

Monthly Gross Income : _____

Other Income : _____

SPOUSE

Name : _____

Employer : _____

Address : _____

Phone # : _____

Monthly Gross Income : _____

Other Income : _____

(Other Income includes: State Assistance, SSI, Child Support, Workman's Comp., Unemployment, Pensions, Rents, Alimony, etc.)

If no income, how do you live? (Live with relatives, etc.) _____

Bank Account Information:

Acct Type: ☐ Savings ☐ Checking Current Balance $ _____

Institution Name & Address: _____

Acct Type: ☐ Savings ☐ Checking Current Balance $ _____

Institution Name & Address: _____

Acct Type: ☐ Savings ☐ Checking Current Balance $ _____

Institution Name & Address: _____

Outstanding Loans/Debt:

House: ☐Own ☐ Rent Current Bal $ _____ Monthly payments $ _____

Mortgage Company/Landlord Name & Address: _____

Credit Card(s): ☐ Master Card Current Bal $ _____ Monthly payments $ _____

☐ Visa Current Bal $ _____ Monthly payments $ _____

☐ Other _____ Current Bal $ _____ Monthly payments $ _____

☐ Other _____ Current Bal $ _____ Monthly payments $ _____

Automobile: Current Bal $ _____ Monthly payments $ _____

Make/Model/Year/Bank/Creditor: _____

Other Monthly Finances:

Rent $_____	Transportation $_____	Clothes $_____	Food $_____
Gas $_____	Telephone $_____	Fuel $_____	Electric $_____
Water $_____	School Supplies $_____	Sewer $_____	Medicine$_____
Insurance $_____	Other_____ $_____	Other_____ $_____	Other_____ $_____

Signature of person completing financial statement **Date Completed**

The hospital's Financial payment policy is listed below. Should you not be able to pay your bill in the amount of period specified, please return this completed financial statement to Nemaha County Hospital and we can determine a monthly payment amount for your services.

The Nemaha County Hospital's Board of Directors has established a policy that states:

1. A bill of $500 or less, must be paid within 6 months of the date of discharge.
2. A bill of $500.01-$1000, must be paid within 12 months of the date of discharge.
3. A bill of $1000.01 & higher, requires a completed financial statement and the amount of payments will be determined by the Financial Services Representative and the CFO.
4. Anytime there is a need to extend payments over the above policy, the guarantor is required to complete a financial statement. The amount of the payment made each month will be determined by the Financial Services Representative and the CFO.

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