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 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 us for information at 402-274-4366.

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 NCH Financial Assistance Application
-Proof of income of all persons in household (W2's, Bank Statements, SSI Statements, Pay stubs)
-Application to Social Services for medical assistance when applicable

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

Responsible Party

Name : _____ Date of Birth: _____ Marital Status: _____
Address: _____ Home Phone: _____ Work Phone: _____
Employer Name & Address : _____ Length of Employment: _____
Housing Arrangement: ▫ Own Home ▫ Rent ▫ Live with parents ▫ Living with Others ▫ Other arrangements
People in Household(**members 19years of age and over will <u>not</u> be considered and will need to apply separately):**

Name	Age	Date of Birth	Relationship to Party	Employer(if applicable)

Spouse/Significant Other

Name : _____ Date of Birth: _____ Marital Status: _____
Address: _____ Home Phone: _____ Work Phone: _____
Employer Name & Address : _____ Length of Employment: _____

Do you have insurance? ▫ Yes ▫ No If yes, name of insurance: _____
_____
Have you applied for Medicaid and been denied? ▫ Yes ▫ No If yes, when?: _____

Monthly Income

	Responsible Party	Spouse/Other Household Members	Total
Gross Earnings			
Disability/SSI/SSA			
Child Support/Alimony			
Other			

Total Monthly Income $

In the absence of income, please tell us how you are providing for the patient's basic living needs:

_____
_____
_____

Please complete the expense information on the reverse side of application, sign, and return to Nemaha County Hospital.

Assets		Liabilities	
Description	Cash Totals or Market Value	Description	Totals Owed
Cash	$	Mortgage Loan or Rent	$
Checking Accounts Name of Bank:		Auto Loan	
Saving Accounts: Name of Bank		Auto Loan	
Life Insurance Net Cash Value		Auto Loan	
Real Estate Owned		Credit Card	
Net Worth of Farm/Business		Credit Card	
Retirement Funds		Credit Card	
Automobiles Owned List Make & Year: Automobiles Owned List Make & Year: Boats, Motorcycles, Campers…		List all Medical Expenses & Locations:	
Other Assets		Other Liabilities	
A - Total Assets	$	B – Total Liabilities	$
Net Worth Total (A minus B) $			

☐ I have completed both the front and back of this application with true and correct information, filling in all of the blanks that apply to me and my situation.

☐ I have included proof of income(3 months from all sources of earnings from each person in the household) which may include: pay stubs, SSI/Disability, W2/Income Tax Return, bank statements, unemployement, Food Stamps Benefits letter, proof of child support, and HUD Verification.

☐ I understand that failure to disclose pertinent information, or providing false information, will disqualify my application from being considered.

Nemaha County Hospital reserves the right to request or access additional information such as IRS Tax return, bank statements, information from the County Assessor, note from employers, and self-employed business records. In the absence of income, details on the patient's basic living needs will be requested.

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 rendered to me by Nemaha County Hospital. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for services provided.

I hereby grant permission to those hospital personnel who are authorized to receive, release or act upon financial information contained herein. I hereby release the designated hospital personnel and all parties who supply information at the request of hospital personnel, from liability for any acts, communications or disclosures which are made pursuant to such an investigation.

Before signing, please review the above and check the box beside each item

_____ _____

Signature of Responsible Party **Date**

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

Date Information Requested: _____ Date NCH received completed info: _____

☐ Verification of Documents ☐ Approved – Financial or Medical By: _____

☐ Denied Condition/Reason for denial : _____

Financial assistance to be provided at a reduction of 100% thru date of ___/___/___ .

Form-120PF3001