PATIENT FINANCIAL ASSISTANCE INSTRUCTION LETTER

Dear Patient:

You may qualify for Partial or Full Financial Assistance, a program provided by Howard County Medical Center. If you are unable to pay for health care services and do not qualify for Federal or State Medical assistance programs, please complete the enclosed Financial Assistance application and return with **all** the required proof of income.

Please be advised that a determination for discount cannot be made until we are in receipt of all the following required information (check the items you have enclosed). **Please return the application by _____,** **or contact our office by that date if you are still in the process of gathering the needed documentation.** The necessary documents we require are:

☐ **Federal Tax Return including W-2 forms for the previous 2 tax years.**
   If you did not keep a copy, you can contact the IRS at 1-800-829-0922 or www.irs.gov to request a free transcript of the Federal Tax Return. If you did not file taxes, you must explain in writing why you did not file.

☐ **Proof of income for the 3 most recent months for guarantor and spouse**
   Proof of income can be copies of pay stubs, a copy of an unemployment check, a copy of a disability check, a copy of the Social Security Award Letter and/or copy of a pension letter.

☐ **Copies of bank statements for the 3 most recent months for all accounts (checking, savings, etc)**

☐ **Letter of Denial from the Department of Health & Human Services**∗∗∗
   To apply for benefits, you can contact the Customer Service Center at 1-855-632-7633 or visit www.dhhs.ne.gov
   ***Not required for applicants with rural health clinic balances

☐ **A letter of explanation for any documentation you are unable to obtain.**

☐ **Each box must be filled in on the enclosed application.**
   For any item that does not apply, please write "N/A"

If you are unable to include one or more of the items above, provide an explanation. This application should be received in our office with all required documentation attached by the date listed above.

If you have any questions, please call the number listed below.

Sincerely,

Patient Accounts
Theresa Robinson
308.754.4421 ext 436

FINANCIAL ASSISTANCE APPLICATION

GUARANTOR	SPOUSE
Name　　　　　　　　　　　Date of Birth	Name　　　　　　　　　　　Date of Birth
Social Security Number　　Home Phone　　Business Phone	Social Security Number　　Home Phone　　Business Phone
Street	Street
City　　　　State　　　　Zip Code	City　　　　State　　　　Zip Code
Household Size _____	Household Size _____
Name and Address of Employer:　_____	Name and Address of Employer:　_____
Position/Title: _____ Length of Employment: _____	Position/Title: _____ Length of Employment: _____

MONTHLY INCOME

	Guarantor	Co – Applicant	Total
Gross Earnings			
Farm/Self Employed			
Disability/SSI			
Child Support/Alimony			
Food Stamps/Gov Assistance			
Military/Pensions			
Dividends			
Other			
Other			

ASSETS***

Under "Details" column, please list institution name for all banking information. For autos, please list year, make, model, and mileage

	Details	Value
Cash on Hand		
Checking Balance		
Savings Balance		
Real Estate		
Vehicles		
Vehicles		
Other (CD, etc)		
Other		

LIABILITIES***

	Balance	Institution
Howard County Medical Center		**Howard County Medical Center**
Real Estate Mortgage		
Rent		
Vehicle Lien		
Vehicle Lien		
Credit Card		
Credit Card		
Credit Card		
Other Loan		
Other Debts		
Other Debts		
Other Debts		
Total Liabilities		
Net Worth		

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PATIENT ACKNOWLEDGMENT

I hereby submit this application for financial assistance to Howard County Medical Center. I acknowledge the above information given to be true and correct and authorize Howard County Medical Center to verify any information given on this form. It is understood and agreed that any misrepresentation by me in this application will be sufficient cause for automatic denial of financial assistance.

Date _____ Signature _____