



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 tax year _____.**
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
- 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
Jamie Oeltjen
308.754.4421 ext 436

FINANCIAL ASSISTANCE APPLICATION

Please return application to:

1113 Sherman Street · Saint Paul, NE 68873 · 308.754.4421 · fax 308.754.2313 · www.hcmc.us.com



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				ASSETS		
	Guarantor	Co – Applicant	Total	Under "Details" column, please list institution name for all banking information. For autos, please list year, make, model, and mileage		
Gross Earnings					Details	Value
Farm/Self Employed				Cash on Hand		
Disability/SSI				Checking Balance		
Child Support/Alimony				Savings Balance		
Food Stamps/Gov Assistance				Real Estate		
Military/Pensions				Vehicles		
Dividends				Vehicles		
Other				Other (CD, etc)		
Other				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						

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 _____

Updated 10/20/17 mlm

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