Patient Financial Assistance Application

Osmond General Hospital

402 N. Maple St. Osmond, Nebraska 68765

DUE BY:

[ ] PRE-DETERMINATION

Include with this application (if relevant)

- ☐ Last 3 months of paycheck stubs or if self-employed, a profit and loss statement for last 3 months
- ☐ Notification of benefits letter for unemployment, disability and/or social security
- ☐ Notification letter for Workers Compensation, report of benefits or copies of check stubs
- ☐ Notification letter for military income or a bank statement if directly deposited
- ☐ Copy of alimony checks or a bank statement if directly deposited
- ☐ Documentation from Child Support Services or a bank statement if directly deposited
- ☐ Documentation from Health and Human Services for food stamps received
- ☐ Most recent Federal income Tax Return with all supporting documents
- ☐ Most recent State Income Tax Return with all supporting documents
- ☐ Last 3 months of bank statements for checking, savings and health savings accounts
- ☐ Documentation of all IRA, Stocks, Bonds, Life Insurance policies

#1 Responsible Party

Last name | First name | Middle name

Address | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow/Widower

#2 Spouse

Last name | First name | Middle

Address (if different from Patients) | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

#3 Dependents

Number of legal dependents _____ Ages of legal dependents _____

#4 Insurance Information

Does anyone in the household have health insurance? [ ] Yes [ ] No

Insured Name #1	Health Ins. Name	Policy number
Insured Name #2	Health Ins. Name	Policy number

#5 Household Monthly Gross Income

	Responsible Party	Spouse
Employment **(Gross Earnings)**	$	$
Self Employment *Business Type_____	$	$
Social Security	$	$
Real Estate Rental Income	$	$
Unemployment- Date Ended _____	$	$
Disability	$	$
Workmen's Compensation	$	$
Child Support	$	$
Alimony	$	$
Military Income	$	$
Food Stamps	$	$
Other	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed

#6 Savings and Investments

☐ I do not have a checking account
☐ I do not have a savings account
☐ I do not have a health savings account

	Responsible Party	Spouse
Checking Account Balance	$	$
Savings Account Balance	$	$
Health Savings Account Balance	$	$
Retirement	$	$
CD/IRA/403b/401k/Annuities/IRA's	$	$
Stocks/Bonds/Interest/Life Ins./Land	$	$
Other Savings and Investments *_____	$	$
TOTAL	$	$

Use additional paper to include any other household members savings or investments not listed

#7 Other Assets

Land				$	$
	Acres		Owner/How Held	Balance Remaining	Assessed Value
Boat				$	$
	Year	Make	Model	Balance Remaining	Book Value
Camper/RV				$	$
	Year	Make	Model	Balance Remaining	Book Value
Motorcycle				$	$
	Year	Make	Model	Balance Remaining	Book Value
ATV				$	$
	Year	Make	Model	Balance Remaining	Book Value
				$	$
				TOTAL	**TOTAL**

#8 Monthly Expenses (please round to nearest dollar)

Housing

[ ] Rent payment	$
[ ] Mortgage payment	$
*Value of Home	$
Additional mortgage payment	$
*Remaining balance	$
Lot rent (mobile homes)	$
Renters insurance	$
Homeowners insurance (If not included in mortgage)	$
Property tax (If not included in mortgage)	$

Housing Utilities

Electric	$
Water	$
Gas	$
Garbage removal	$
Telephone (land line)	$
Telephone (cellular)	$
Cable and Internet	$

Transportation/Vehicles

Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Insurance	$
Gasoline/Diesel	$

Medical

Health insurance	$
Life insurance	$
Dental insurance	$
Medications	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$

#8 Monthly Expenses (continued)

Credit Cards

Name		
Payment	$	
Balance	$	
Name		
Payment	$	
Balance	$	
Name		
Payment	$	
Balance	$	
Name		
Payment	$	
Balance	$	

Other Expenses

Type		
Payment	$	
Balance	$	
Type		
Payment	$	
Balance	$	
Type		
Payment	$	
Balance	$	
Type		
Payment	$	
Balance	$	

Miscellaneous

Food and Paper Products	$	Child Care	$
Clothing/Shoes	$	Child Support	$
Entertainment	$	Alimony Paid	$
Charity Contributions	$	Lawn Care	$
Newspaper	$	Snow Removal	$

TOTAL EXPENSE (For Office Use Only) $ X 12 = $

#9 Other Comments

#10 Assignment of Rights

I understand that proof of income (see Financial Assistance Checklist) is required to process my application. I also understand that more information may be requested before my eligibility can be determined.

I hereby acknowledge that the information listed on this application is true and correct. If any information given proves to be untrue or is withheld I understand the hospital may take whatever action is appropriate. This action may include denial of this application up to and including denial of all future applications.

I agree that I will repay the assistance I was rewarded if I receive payment of any kind for the medical services covered by this application. Examples of this would be: insurance payments, payments from government programs, lawsuit settlements, or any other source of payment received.

Signature Date

Signature Date

You must be a US Citizen, US National, or alien lawfully present in the United States in order to qualify for any type of financial assistance offered by Osmond General Hospital