Memorial Hospital
Patient Accounts Department
300 North Columbia Avenue
Seward, NE 68434
402-646-4704

Financial Assistance Application

Applicant (Responsible Party)

Name ______________________________ Date of Birth ______________________________

Social Security Number ______________________________ Home Phone ____________ Work Phone ____________ Cell Phone ____________

Address ____
Street Apt.# City, ST Zip

Marital Status ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Employer ______________________________ Address of Employer ______________________________

Position/Title ______________________________ Length of Employment ______________

Housing Arrangement ☐ Own Home ☐ Living with parents ☐ Living with other ☐ Other arrangements: ______________________________

People in Household:

NAME	AGE	RELATIONSHIP TO RESPONSIBLE PARTY	EMPLOYER (if applicable)

Co-Applicant (Spouse/Significant Other)

Name ______________________________ Date of Birth ______________________________

Social Security Number ______________________________ Home Phone ____________ Work Phone ____________ Cell Phone ____________

Employer ______________________________ Address of Employer ______________________________

Position/Title ______________________________ Length of Employment ______________

Insurance Information

Do you have insurance? ☐ Yes ☐ No If yes, name of insurance: ______________________________

Have you applied for Medicaid and been denied? ☐ Yes ☐ No ***If yes, please attach proof of denial.***

****IF YOU HAVE NOT APPLIED FOR MEDICAID YOU MAY BE REQUIRED TO BASED ON YOUR INCOME****

Do you have any other payor sources for these accounts? (i.e., Aflac, Hartford, State Farm) ☐ Yes ☐ No

*** If yes, name source: ____________________**

Do you have access to Health savings funds (HSA or HRA) to be used for medical expenses? ☐ Yes ☐ No **If yes, how much? ______________**

Monthly Income

Please complete the following fields by calculating the average monthly GROSS income for each category based on the past six (6) months prior to the application date

	Responsible Party	Spouse or other Household Members	TOTAL
Gross Earnings			
Farm/Self Employment			
Pensions/Interest/Dividends			
Work Comp			
Disability/SSI/SSA			
Military			
Child Support/Alimony			
Unemployment			
ADC/Food Stamps			
Other			
		Total Monthly Income	$

Any current changes to the averages listed above should be explained in the following space provided:

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____

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Assets

Description	Cash Totals or Market Value
Cash	$
Checking Accounts **Name of Bank:** ______________________	
Savings Accounts **Name of Bank:** ______________________	
Life Insurance Net Cash Value	
Real Estate Owned	
Net Worth of Farm or Business Owned	
Retirement Funds **(Pensions, IRAs, Mutuals, 401k, other)**	
Automobiles Owned **List Make and Year:** __________________	
Automobiles Owned **List Make and Year:** __________________	
Boats, Motorcycles, Campers, Antiques	
Other Assets	
Total Assets	$

Liabilities

Description	Total Owed
Mortgage Loan or Rent	$
Utilities	
Auto Loan	
Auto Loan	
Credit Card	
Credit Card	
Credit Card	
List Other Loans and Locations	
List Other Loans and Locations	
List Medical Expenses and Locations **(attach copies of bills)**	
Other Liabilities	
Total Liabilities	$

Before signing, please review the following and initial the box beside each item to confirm:

- [ ] I have completed both the front and back of this application with true and correct information, filling in all fields that apply to my situation and/or that of all applicable household members.
- [ ] I have included current proof of income for two (2) months from all sources of earning for each person in my household (pay stubs, unemployment/SSI/Disability/SSA Statements). **Your application will NOT be processed without these documents.**
- [ ] I have included signed Federal Income Tax returns for the most recent tax year for all applicable household members, or written explanation of the absence of this requirement. **Your application will NOT be processed without these documents.**
- [ ] I have included copies of bank statements for all accounts listed within this application in the “Assets” section above for the two most recent months. **Your application will NOT be processed without these documents.**
- [ ] I understand that failure to disclose pertinent information, or providing false information, will disqualify my application from being considered for financial assistance.

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 Memorial 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 financial assistance, 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.

I agree to tell Memorial Hospital within 10 days, if there are any changes in my (or the persons on whose behalf I am acting) income, property, expenses, change in address, or changes in household members.

I understand that I may be asked to prove my statements and that my eligibility statements will be subject to verification by contact with my employer, bank, credit verification, and property searches.

I understand that the hospital is required by law to keep any information I provide confidential.

I further agree, that in consideration for receiving healthcare services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such act.

I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by Memorial Hospital or I may appeal the decision in writing with additional documentation.

______________________________	______________________________	____________________
Applicant Signature	**Co-Applicant Signature**	**Date**