NEMAHA VALLEY
Community Hospital & Seneca Family Practice

APPLICATION FOR FINANCIAL ASSISTANCE

Patient's Name _____ Date of Birth_____

Address_____City_____State_____Zip Code_____

Social Security Number _____-_____-_____ Home Phone _____

Employer _____ Family Size _____

Family Member Names: _____

FINANCIAL POSITION:

Income : List Total Household Income.

Employer : _$_____ Unemployment:_$_____

Social Security:_$_____ Disability:_$_____

Child Support:_$_____ Other: _$_____

ASSETS:

Checking: yes no Savings: yes no CD: yes no Other: yes no

MONTHLY EXPENSES: list amount, if no amount list reason why

Rent/Mortgage: _____ Electric/Heating:_____

Water: _____ Food:_____

Auto Loan: _____ Auto Insurance: _____

Transportation Costs:_____

Telephone:_____ Cable/TV:_____

Installment Bills: _____

Medical/Dental:_____

Other Expenses: _____

SCREENING QUESTIONS:

1. Do you receive any benefits from DCF? If so what do you receive?_____

2. Are you Disabled? Yes No What is your disability? _____

   Date Disability Began: _____

3. Do you have a child that is disabled? _____

   Do they receive SSDI?_____ If so how much?: _____

4. Are you pregnant? _____ If so what is your due date? _____

5. Reason for Hospitalization/Clinic Need: _____

6. Date of Hospitalization: _____

7. Amount of Hospital/Clinic Bill: _____

8. Reason for application: _____

_____

9. Who is your primary care physician? _____

Applicants Signature: _____ Date:_____

I certify that this information is true and hereby authorize Nemaha Valley Community Hospital to verify said information.

Items that must accompany the application:

a) Copy of all earning statements (pay stubs) for the last 3 months
b) Copy of checking and savings for last 3 months.
c) Copy of the most recent federal tax return.

* The above information must be received with the application or the application will be considered incomplete and may delay determination. Financial Assistance is not a substitute for personal responsibility and all patients are expected to contribute to the cost of their care based on their individual ability to pay.

Please return the application and documentation within 30 days to:

Nemaha Valley Community Hospital
Attention: Business Office
1600 Community Drive
Seneca, KS 66538

*A Medicaid or Healthwave denial might be required before approval of application. If you are required to apply for these services, we will notify you. For questions or assistance in filling out the application call Deanna Wullschleger at 785-336-0434 or Karla Hermesch 785-336-0421

Finance Service Area

Date Received: _____ Application Reviewed By: _____

Does this application warrant a Medicaid or Healthwave Denial? _____

Information Received:

___ Copy of the last 3 months earning statements. ___ Copy of any assets

___ Copy of most recent Federal Tax Return ___ Copy of Medicaid or Healthwave denial if necessary

Sponsorship Determined: Full - Partial - Pending - Denied (circle one)

Sponsored Care Worksheet completed: Yes No

Acknowledgement Returned to Applicant _____ (date/initials)