



APPLICATION FOR FINANCIAL ASSISTANCE

Patient's Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip Code _____
Social Security Number _____ Phone Number _____
Employer _____ Family Size _____
Family Member Names: _____

FINANCIAL POSITION:

INCOME: List Total Household Income. Circle whether listed amount is per month or per year.

Employment: \$ _____ per month per year (include most recent 3 months' pay stubs)
Social Security: \$ _____ per month per year
Unemployment: \$ _____ per month per year
Disability: \$ _____ per month per year
Child Support: \$ _____ per month per year
Other: \$ _____ per month per year

ASSETS: (circle applicable answer and include most recent 3 months' statements)

Checking account: Yes No Savings account: Yes No CD(s): Yes No Other: Yes No

MONTHLY EXPENSES:

Rent/Mortgage: _____ Electric/Heating: _____
Water: _____ Food: _____
Auto Loan: _____ Auto Insurance: _____
Transportation Costs: _____ Telephone: _____
Medical/Dental: _____
Other Expenses: _____

SCREENING QUESTIONS:

- 1. Do you receive any benefits from Department for Children and Families (DCF)? Yes No
If yes, 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? Yes No
Do they receive Social Security Disability Income (SSDI)? Yes No
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 recently filed federal tax return.

* The above information must be received with the application, or the application will be considered incomplete and determination may be delayed. 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 may 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 Hermes 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)