Chadron Community Hospital and Health Services

FINANCIAL ASSISTANCE APPLICATION

APPLICATION FOR ELIGIBILITY DETERMINATION

Patient/Responsible Person Name		Date Requested	
Address		Phone Number	
Requested by		Relationship to Patient	
Address			
Spouse/Significant Other Name			
Number of Children in Family			
How Long at Current Address		Marital Status	Total Number in Household

EMPLOYMENT & INCOME

Present Employer		How Long	
Address		Monthly Gross Income	$
Spouse/Significant Other Employer		How Long	
Address		Monthly Gross Income	$
Patient Other Income – see below	$	Source of Other Income	
Spouse/Significant Other Income	$	Source of Other Income	
Annual Gross Household Income	$		

INSURANCE AND DOCUMENTS

Have you applied for Medicaid?	☐ Yes ☐ No	If yes and rejected, reason	

Can you be claimed as a dependent on someone else's tax return? ☐ Yes ☐ No **If Yes, include their tax returns and income information**

Have you applied for the Health Insurance Exchange Options? ☐ Yes ☐ No

If NO, please indicate why
- ☐ Employer offers health insurance coverage and I am covered by the plan
- ☐ Employer offers health insurance coverage but I did not sign up
- ☐ Employer does not offer health insurance coverage
- ☐ Self-employed

Documented Proof of all Income is Required and Must Accompany Your Application for yourself and spouse, partner, or other family member contributing to household.

☐ Federal Tax Returns (last 2 years) – If you can be claimed on someone else's tax return, you MUST provide that person's tax returns

☐ 3 Months Current Pay Stubs – must include Spouse/Significant Other

☐ 3 Months Current Bank Statements – must include Spouse/Significant Other

Other Income Source(s) – attach supporting documents

☐ Alimony	☐ Food Stamps/Housing	☐ Railroad Retirement	☐ VA Assistance
☐ Child Support	☐ Life Insurance	☐ Social Security	☐ Worker's Compensation
☐ Disability	☐ Pension	☐ Unemployment	☐ Other _____

HOSPITAL INFORMATION

Date of Admission:		Date of Dismissal:		Total Charges:	
Payments to Date:		Balance Due:			

FINANCIAL ASSISTANCE CHECKLIST

Initial if YES	INFORMATION REQUIRED FOR COMPLETE APPLICATION Do Not Send Original Documents – Please Send Only Copies of Your Supporting Documents
	1. The demographic information is completed for the patient/responsible person and spouse/significant other (name, address, etc.)
	2. The dependent information is completed (number in household, ages, etc.)

	3. The employment and income information is completed for the patient/responsible person and spouse/significant other.
	4. Copies of last 2 years tax returns including spouse/significant other/parent are attached.
	5. If self-employed, schedules C, E, F and IRS Form 8965 (Health Insurance Coverage Exemption) are required.
	6. Copies of 3 most recent months' pay stubs (or employment benefit) are attached for the patient and spouse/significant other/parent.
	7. If applicable, a copy of current year social security benefits for you and your spouse/significant other/parent are attached.
	8. If applicable, a copy of workers compensation benefit you and your spouse/significant other/parent receive are attached.
	9. If you applied for Medicaid and were denied, a letter of denial is attached.
	10. If you have limited income and another party is helping you meet your daily needs, the Letter of Financial Support at the bottom of this form has been completed.
	11. I am enrolled as a traditional college student.

DISCLAIMER AND SIGNATURE

I understand that the information which I submit is subject to verification by Chadron Community Hospital and subject to review by Chadron Community Hospital Board of Directors as required. I certify that the above information is true and correct.

Date:		Signature of person making request:	
Investigated By:		Recommendation:	
Date:		Request:	☐ Approved ☐ Denied

LETTER OF FINANCIAL SUPPORT (SEE #10 ABOVE)

I, _____ certify that I am providing the applicant with the following support each month:

(List specific support: food, heat, telephone, shelter, etc.) _____

_____

The total cost of this support is $ _____. I do not ask or expect to be reimbursed for the cost of this support. I provide support because: (List reason: short term medical situation, short term unemployment, recent relocations, etc.) _____

_____

I have been providing this support for _____ months. I understand that my signature does not make me liable for his/her debts. I certify that this information I provided is true.

Supporter's Signature: _____ Date: _____

Name (printed) _____

Street Address _____ City: _____

State: _____Zip Code: _____ Phone Number: _____

Please send application and supporting documentation to Financial Assistance, Chadron Community Hospital and Health Services, 825 Centennial Drive, Chadron, NE 69337