

Chadron Community Hospital and Health Services
FINANCIAL ASSISTANCE APPLICATION

APPLICATION FOR ELIGIBILITY DETERMINATION

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

EMPLOYMENT & INCOME

Present Employer		How Long		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
Address			Monthly Gross Income	\$
Spouse/Significant Other Employer		How Long		<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time
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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes and rejected, reason	
Have you applied for the Health Insurance Exchange Options? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, please indicate why <ul style="list-style-type: none"> <input type="checkbox"/> Employer offers health insurance coverage and I am covered by the plan <input type="checkbox"/> Employer offers health insurance coverage but I did not sign up <input type="checkbox"/> Employer does not offer health insurance coverage (letter from Employer required) <input type="checkbox"/> Self-employed 			
Documented Proof of all Income is Required and Must Accompany Your Application <input type="checkbox"/> Federal Tax Returns (last 3 years) – If you can be claimed on someone else’s tax return, you MUST provide that person’s tax returns <input type="checkbox"/> 3 Months Current Pay Stubs – must include Spouse/Significant Other <input type="checkbox"/> 3 Months Current Bank Statements – must include Spouse/Significant Other			
Other Income Source(s) – attach supporting documents <input type="checkbox"/> Alimony <input type="checkbox"/> Food Stamps/Housing <input type="checkbox"/> Railroad Retirement <input type="checkbox"/> VA Assistance <input type="checkbox"/> Child Support <input type="checkbox"/> Life Insurance <input type="checkbox"/> Social Security <input type="checkbox"/> Worker’s Compensation <input type="checkbox"/> Disability <input type="checkbox"/> Pension <input type="checkbox"/> Unemployment <input type="checkbox"/> Other _____			

ASSETS AND EXPENSES

Assets		Monthly Expenses			
Cash on Hand - Checking	\$	Housing Payment/Rent	\$	<input type="checkbox"/> Rent <input type="checkbox"/> Own	
Cash on Hand – Savings	\$	Vehicle Loan	\$	Payment	\$
Stocks/Bonds/Land/Cattle	\$	Vehicle Loan	\$	Payment	\$
Vehicle – Make	Year	Child Support	\$		
Vehicle – Make	Year	Credit Cards	\$	Payment	\$
Home – Estimated Market Value	\$	Other Loan	\$	Payment	\$
Other Assets	\$	Other _____	\$		
Monthly Utilities:	Gas: _____	Electric: _____	Water: _____	Phone: _____	Cable/Other: _____

HOSPITAL INFORMATION

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

FINANCIAL ASSISTANCE CHECKLIST

Initial if	INFORMATION REQUIRED FOR COMPLETE APPLICATION
YES	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 3 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 your employer does not offer a health insurance plan option, a letter from your employer is attached.
	11. I am currently enrolled as a traditional college student and therefore, I do not qualify for Financial Assistance.
	12. 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.

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:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied

LETTER OF FINANCIAL SUPPORT (SEE #12 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 Note: Traditional College Students DO NOT Qualify.

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