



## Financial Assistance Application

### Part I-Personal Information

Guarantor's Full Legal Name	Relationship to Patient
Social Security Number	Other names (e.g. maiden name) Guarantor Uses
Patient's Full Legal Name	
Mailing Address	Phone Number
Guarantor Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	
Spouse's Full Legal Name	Social Security Number
Other names (e.g. maiden name) Spouse Uses	

### Part II-Work Information

#### Guarantor

Name of Employer	Employer Address	Employer Phone Number
Occupation	Length of Employment	Gross Monthly Salary
If not presently employed, name and address of last Employer		Occupation

#### Spouse

Name of Employer	Employer Address	Employer Phone Number
Occupation	Length of Employment	Gross Monthly Salary
If not presently employed, name and address of last Employer		Occupation

**Part III – Health Insurance Information**

Medical Insurance      Yes  No  If "yes" name of insurance company: \_\_\_\_\_

Other third party coverage      Yes  No  If "yes" name of insurance company: \_\_\_\_\_

COBRA coverage available      Yes  No  If "yes" provide monthly premium amount: \_\_\_\_\_

Medicare coverage      Yes  No  Medicare Supplement?      Yes  No

Medicaid coverage      Yes  No  If "yes" which State provides this coverage: \_\_\_\_\_

If "No" have you applied for Medicaid in the past, and if denied, why?

Is the medical treatment because of an auto accident or other third party injury?      Yes  No

Is the medical treatment because of an employment injury or occupational disease?      Yes  No

If "yes" to either of the above two questions, provide workers compensation or third party liability insurance information

**Part IV – Dependents and/or Member of the Household**

Please list all members of household in which you reside (including those you do not support financially)

Name	Relationship	Age	Monthly Income	Dependent(Y/N)

**Part V-Income and Expense Information**

Household Income	Monthly total	Family Expenses	Monthly Total
Responsible Party Salary (GROSS)		House Rental/Payment	
Parent/Spouse's Salary (GROSS)		Food	
Tips		Monthly Utilities	
Social Security Benefits		Monthly Insurance Premiums	
Pension		Car Payments	
Disability Benefits		Cable/Satellite TV & Internet	
State Assistance		Child Care	
Workers Compensation		Phone Services	
Food Stamps		Monthly medical payments	
Alimony/Child Support		(List in detail in Part VII)	
Rental Income		Credit card payments	
Business Income		Loan payments	
Interest Income		(List in detail in Part VI)	
Unemployment Compensation		Child Support	
Other (Describe)		Other (Describe)	
<b>Total</b>	<b>\$</b>	<b>TOTAL</b>	<b>\$</b>

**Part VI-Assets and Financial Obligations**

Assets		Financial Obligations	
House/Land Value		Mortgage	
Vehicle #1		Auto loan on Vehicle #1	
Vehicle #2		Auto loan on Vehicle #2	
Vehicle #3		Auto loan on Vehicle #3	
Savings account (Bank name)		Personal property loans	
Checking account (Bank name)		Life insurance loans	
Guns/jewelry over \$500		Credit card #1 balance	
Retirement funds/pensions		Credit card #2 balance	
Recreational vehicles		Other installment loans	
Other assets (Specify)		Other liabilities (Specify)	
<b>Total</b>	\$	<b>Total</b>	\$

**Part VII-Medical Financial Obligations**

Facility Name	Balance Owed	Monthly Payment
<b>TOTAL</b>	\$	\$

**Part VII-Special Financial Circumstances**

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next three (3) months?

Yes    No      If "yes", please explain:

Have you recently suffered severe financial hardship or personal loss (other medical expenses, death of a loved one, loss of job or wages loss of home, auto or other property)?

Yes    No      If "yes", please explain:

If you answered yes to the previous question, please attach supporting documents that reflect your current financial situation. If you cannot attach supporting documentation please explain below:

### Part IX-Other Special Circumstances

Please tell us about any other special circumstances that would help us evaluate your need for financial assistance. Attach separate sheet if additional space is needed.

### Part X-Attachments

- Medicaid correspondence-I.E.-Proof of Application, Denial, or Out of State Medicaid Card
- Most recent federal tax returns for all working Individuals in the household **OR** three months of pay stubs from all working individuals in the household **OR** signed support letter.
- Documents that reflect other income-recent public assistance benefits, unemployment benefits, social security benefits, workers compensation, child support or other income check stub.
- Documents that reflect your current financial information described in part VII

### Part X-Signature

- I certify that the information provided is true and accurate to the best of my knowledge.
- I authorize Thayer County Health Services and/or its agents to verify the information in this application. This verification may include inquiry of my credit history through a credit reporting agency, correspondence with bank regarding account balances or use of other means, as deemed necessary, to verify accuracy of this information.
- I understand that if any of this information proves to be untrue Thayer County Health Services may deny financial assistance previously awarded.
- I understand that I may be asked to secure a source of payment from an outside source. These sources may include Medicaid, community assistance programs, and a Union Bank Loan. Refusal to cooperate may result in denial of charity.
- I understand that balances are due within 30 days from the date that charity is denied or awarded. If you are unable to pay the balance in full in 30 days, please contact our financial assistance department at 402-768-4613 to set up payment arrangements

Signature of Guarantor/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_