COMMUNITY HOSPITAL
Advanced care. Always there.

RE: Financial Assistance

Community Hospital offers a program for financial assistance to individuals whose income or net worth qualifies them for participation. Under this program the hospital provides a reasonable amount of assistance to those who meet the policy guidelines and are not eligible for assistance from the Department of Health and Human Services. If you meet the guidelines, we can assist you with all or part of the charges.

Attached you will find an application form for Financial Assistance. Please complete this form and the following information is **REQUIRED**:

- **Verification of income on all amounts listed** (i.e. recent tax return, W-2s, paycheck stubs, bank statements, social security letter or letter from an employer)
- **Current Bank Statement for Checking and Savings accounts**
- **Current bills for Medical Expense amounts listed to other providers**

The verification of income you provide must be for the past three months or the past twelve months. You are also required to **list all assets and corresponding debt**. This includes your bank balances, home, vehicles, recreational vehicles, equipment, etc.

Please read the form carefully, sign, and return by mail, email, FAX (308-344-8316) or in person. After your application is returned, a determination will be made and you will be notified by mail. If you have questions on this program or filling out the application, please feel free to call one of the Financial Counselors at Community Hospital.

Sincerely,

Laci Ingels
Patient Financial Counselor
lingels@chmccook.org
(308) 344-8334

Lynn Soncksen
Patient Financial Counselor
lsoncksen@chmccook.org
(308)344-8322

COMMUNITY HOSPITAL
APPLICATION FOR FINANCIAL ASSISTANCE

INSTRUCTIONS: Please complete both sides of the application including the signature line on the back page.
The following documentation is REQUIRED:

- **Verification of income on all amounts listed** (i.e. recent tax return, W-2s, paycheck stubs, bank statements, social security letter or letter from an employer)
- **Current Bank Statements for Checking and Savings accounts**
- **Current bills for Medical Expense Amounts listed**

Patients who submit an incomplete application will be sent a letter identifying and requesting the missing information and if the additional information is not received within 30 days the application will be closed.

HOUSEHOLD INFORMATION

Name_____ SS#_____

Spouse/Significant Other_____ SS#_____

Address_____Phone #_____

City, State, Zip _____Cell Phone# _____

Dependent Names/Ages_____

INCOME INFORMATION

SELF
Employer_____

Address_____

Phone #_____

Monthly Gross Income_____

SPOUSE/SIGNIFICANT OTHER
Employer_____

Address_____

Phone #_____

Monthly Gross Income_____

Other Monthly Income:_____ Type: _____

Other Monthly Income:_____ Type_____

(Other Income examples include: SSI, Child Support, Workman's Comp., Unemployment, Pension, Rent, Alimony, etc.)

If you do not have monthly income, please explain how you take care of your monthly expenses.

_____

_____

_____

FINANCIAL INFORMATION

Do you use a bank for financial transactions? YES / NO

If Yes, please provide current balances: Checking Balance $_____

Savings Balance $_____ HSA/FSA $_____

If No, how do you handle your financial transactions? (i.e. prepaid card, cash, etc.)

_____

Assets & Liabilities:

	Value	Balance Due
Primary residence	$_____	$_____
Secondary residence	$_____	$_____
Vehicle #1 Make_____Year_____	$_____	$_____
Vehicle #2 Make_____Year_____	$_____	$_____
Vehicle #3 Make_____Year_____	$_____	$_____
Other Assets (Including: Artwork, Jewelry, Recreational Vehicles, Campers, etc.)		
_____	$_____	$_____
_____	$_____	$_____
Liabilities:		
Payment to_____for_____		$_____
Payment to_____for_____		$_____
Payment to_____for_____		$_____
Payment to_____for_____		$_____

Self-employed include:

Trade tools/equipment	$_____	$_____
Business Real Estate	$_____	$_____
Business Vehicles	$_____	$_____

Other Medical Bills:

Provider_____	$_____
Provider_____	$_____
Provider_____	$_____
Provider_____	$_____
Provider_____	$_____

Comments: _____

_____

_____

I currently participate in a Christian ministry cost sharing health plan? Yes_____ No_____

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any other assistance which may be available for payment of my hospital charges (Medicaid, Insurance, etc.), and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by Community Hospital. I hereby grant permission to Community Hospital to investigate the information contained herein.

Signature_____Signature_____ Date_____