Brown County Hospital
Quality
In Community Healthcare
Ainsworth, Nebraska 402-387-2800
www.browncountyhospital.org

Financial Assistance Application

SECTION I: PERSONAL INFORMATION

Last Name	First Name	M.I.	SSN	Date of Birth

Address	City	State	Zip Code

Home Phone	Cell Phone	Work Phone

Family/Household Member First and Last Name	Dependent (Yes)/(No)	Relationship	DOB	SSN
1				
2				
3				
4				
5				

Employment

Applicant's Employer Name	Applicant's Employer Address	Job Title	Employer Phone Number

Spouse's Employer Name	Spouse's Employer Address	Job Title	Employer Phone Number

Current Medical Insurance Coverage

Name of Plan(s)

If No Medical Insurance coverage, please provide the following:

	Circle One	If Y, please provide brief explanation why not participating in plan
Does Applicant's Employer Provide Health Coverage	Y / N	
Does Spouse's Employer Provide Health Coverage	Y / N	
Have you applied for insurance via the commercial market?	Y / N	
Have you applied for insurance via healthcare.gov?	Y / N	
Have you applied for Medicaid?	Y / N	

If you are uninsured, and no applications for health insurance coverage have been made, please provide brief explanation as to why not:

SECTION II: ASSETS

Cash and Investments

Cash on Hand & Checking Account Balance	$
Savings Account Balance	$
Investments	$
Retirement Accounts	$
Other: _____	$
Total Cash and Investments:	**$**

Non-Cash Assets

		If Yes, estimated value if $5,000 or more
Do you own a home(s)?	Y / N	$
Do you own other property?	Y / N	$
Do you own automobiles?	Y / N	$
Other: _____		$
Other: _____		$

SECTION III: INCOME

Source of Income:	Applicant Monthly Gross	Spouse Monthly Gross	Dependent(s) Monthly Gross
Salary/Wages	$	$	$
Social Security Benefits	$	$	$
Alimony / Child Support	$	$	$
Pension Payments	$	$	$
Other - Please Specify:	$	$	$
_____	$	$	$
_____	$	$	$
Total Monthly Income:	**$**	**$**	**$**

Income verification must accompany this application. Documents to support income verification can include the following:

- Most current complete tax return (preferred)
- Most recent pay stub(s)
- Most recent unemployment check(s)
- W-2's
- SSI Disability Determination letter
- Other documentation as requested

SECTION IV: EXPENSES

Routine Expenses (Monthly)	
Mortgage / Rent	$
If none, source of housing:	$
Utilities	$
Telephone	$
Food	$
Medical Insurance Premiums	$
Alimony / Child Support	$
Auto Loans	$
Finance Companies	$
Auto/Property Insurance Premiums	$
Medications	$
Other:	$
Other:	$
Total Routine Monthly Expenses:	**$**

Unpaid Medical expenses you are responsible for at this time:

Medical Provider	Unpaid Amount
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total Unpaid Medical Expenses:	**$**

SECTION V: CERTIFICATION BY APPLICANT

I declare under penalty of perjury that the answers I have given are true and complete to the best of my knowledge.

I understand that I may be asked to prove my statements and that my eligibility statements may be subject to verification by contact with my employer, credit verification, and property ownership searches.

I understand that it is my responsibility to advise the hospital of any change in status in regards to my income or assets, while this application is in process and if approved, for the entire period I am receiving financial assistance.

I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by the Hospital and/or Clinic.

_____ _____

Signature of Applicant Date