St. Peter's Health

MAIL TO: PO Box 1537, Bellevue, NE 68005

FINANCIAL ASSISTANCE APPLICATION

ACCOUNT NUMBER										

Department Location: _____

Guarantor's Last Name, First	Date of Birth	Social Security Number	Source of income: ☐Employed ☐Retired ☐Unemployed ☐Disabled
Spouse's Last Name, First	Date of Birth	Social Security Number	Source of income: ☐Employed ☐Retired ☐Unemployed ☐Disabled

Guarantor's Address	Home Telephone Number	Cell Telephone Number (optional)
Case worker (If referred)		

Dependent's Last Name, First	Date of Birth	Dependent's Last Name, First	Date of Birth
Dependent's Last Name, First	Date of Birth	Dependent's Last Name, First	Date of Birth
Dependent's Last Name, First	Date of Birth	Dependent's Last Name, First	Date of Birth

I need Financial Assistance for:

☐ **Hospital / Medical bills** ☐ **Oxygen / C-Pap** ☐ **Pharmacy (340B)**

Please read before signing. I CERTIFY the information I have provided is true and accurate to the best of my knowledge. I agree to apply for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay my bill(s) and will take all action necessary to obtain assistance from the above sources. I understand that if I do not cooperate with and provide St. Peter's Health, within 30 days from the date of service, ANY additional information requested, my application for possible financial assistance may be denied. I hereby grant permission and authorize any accredited agent of federal, state, local government and private sources to disclose to St. Peter's Health ALL information regarding the status of my application(s) and, if the application is not approved, the reason for such determination. I will ASSIGN to ST. PETER'S HEALTH ALL FUNDS received from the above sources, which are provided to help with this MEDICAL BILL(S). I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s) and provider(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communications and/or oral discussions between St. Peter's Health and me regarding matters relating to services provided to me by St. Peter's Health. I understand that the information which I submit is subject to verification by ST. PETER'S HEALTH, including credit reporting agencies, and subject to review by FEDERAL, and/or STATE AGENCIES and others as required. I UNDERSTAND that if any information I have given proves to be untrue, ST. PETER'S HEALTH will reevaluate my financial status and take whatever action becomes appropriate.

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SIGNATURE OF APPLICANT	*DATE*	*STAFF SIGNATURE UPON RECEIPT*	*DATE*

In order to be considered for our assistance program, a completed application form and all supporting documentation must be received. Failing to provide the requested information may lead to the denial for assistance. Please furnish the below documentation for all family members in the household.

☐ Please mark this spot if you are uninsured and we will refer you to attempt to qualify for any Federal or State available insurance coverage. You will be expected to follow through/comply with government required application process**. (Medicaid-DPHHS / Marketplace-Healthcare.gov)**

Please mark if you qualify for any of these public assistance programs and **supply the current letter** with your application.

☐ Snap (Food Stamps) Award Letter showing all members of household
☐ Housing assistance Letter

If the above does not apply, please proceed.

☐ Previous year's Federal tax return in **FULL**. If your current income has drastically changed from the previous year, please provide your most recent paystub including year-to-date in addition to the tax return. We do not accept W-2s.

STOP, if you have one of the above, you do not need to supply any further documentation.

If you no longer file taxes, please Proceed

☐ If you are self-employed, please supply a Profit and Loss for the past 2 quarters.
☐ Unemployment compensation
☐ Workers' compensation
☐ Social Security - please supply most recent Cost of Living Adjustment letter (COLA)
☐ Pension (please supply current award letter)
☐ Veterans' payments
☐ Survivor benefits
☐ Rental income
☐ Income from estates
☐ Trusts
☐ Educational assistance
☐ Alimony
☐ Child support
☐ Assistance from outside the household
☐ The last 2 months of bank statements in full for **ALL** checking and savings accounts in your household's name with Paystubs.

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If you have no income, please make an appointment with a financial counselor to discuss further documentation needed.

We may request additional documentation for consideration of the Patient Assistance Application.