



St. Peter's Health

MAIL TO: PO Box 1537, Bellevue, NE 68005

FINANCIAL ASSISTANCE APPLICATION

ACCOUNT
NUMBER

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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)	

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 do need Financial Assistance.

Please read before signing. I CERTIFY the information I have provided is true and accurate to the best of my knowledge. 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, 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.

SIGNATURE OF APPLICANT	DATE	STAFF SIGNATURE UPON RECEIPT	DATE



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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

STEP 1

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

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

STEP 2

☐ Most recent paystub showing gross YTD earnings for **ALL** working members of the household

☐ Most current tax return in **FULL**. If you no longer file taxes, please go to STEP 3

STOP, if you provide the above documents from STEP 2, you do not need to supply any further documentation.

STEP 3

☐ If you are self-employed, please supply a Profit and Loss for the past 2 quarters.

☐ Unemployment compensation

☐ Workers' compensation income

☐ Social Security income (please supply most recent Cost of Living increase letter)

☐ Pension income (please supply current award letter)

☐ Veterans' payments income

☐ Survivor benefits income

☐ Rental income

☐ Income from estates

☐ Trust Income

☐ Educational financial assistance

☐ Alimony payments

☐ Child support payments

☐ Financial assistance from outside the household

☐ The last 2 months of bank statements to show potential income

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

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

Patients will not be denied care based on inability to pay.