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)

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 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.

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
_____ Social Security (please supply most recent Cost of Living increase letter)
_____ Pension (please supply current award letter)
_____ Veterans' payments
_____ Survivor benefits
_____ Rental income
_____ Income from estates
_____ Trust Income
_____ Educational assistance
_____ Alimony
_____ Child support
_____ Assistance from outside the household
_____ The last 2 months of bank transactions in full for **ALL** checking and savings accounts in your household's name.

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.