Patient Financial Assistance Application

2700 Norfolk Avenue | Norfolk, Nebraska 68701 | www.frhs.org

DUE BY:

[ ] PRE-DETERMINATION

Include with this application (if relevant)

- ☐ Last 3 months of paycheck stubs or if self-employed, a profit and loss statement for last 3 months
- ☐ Notification of benefits letter for unemployment, disability and/or social security
- ☐ Notification letter for Workers Compensation, report of benefits or copies of check stubs
- ☐ Notification letter for military income or a bank statement if directly deposited
- ☐ Copy of alimony checks or a bank statement if directly deposited
- ☐ Documentation from Child Support Services or a bank statement if directly deposited
- ☐ Documentation from Health and Human Services for food stamps received
- ☐ Most recent Federal income Tax Return with all supporting documents
- ☐ Most recent State Income Tax Return with all supporting documents
- ☐ Last 3 months of bank statements for checking, savings and health savings accounts
- ☐ Documentation of all IRA, Stocks, Bonds, Life Insurance policies

#1 Responsible Party

Last name | First name | Middle name

Address | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

[ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widow/Widower

#2 Spouse

Last name | First name | Middle

Address (if different from Patients) | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

#3 Dependents

Number of legal dependents _____ Ages of legal dependents _____

#4 Insurance Information

Does anyone in the household have health insurance? [ ] Yes [ ] No

Insured Name #1	Health Ins. Name	Policy number
Insured Name #2	Health Ins. Name	Policy number

#5 Household Monthly Gross Income

	Responsible Party	Spouse
Employment **(Gross Earnings)**	$	$
Self Employment *Business Type_____	$	$
Social Security	$	$
Real Estate Rental Income	$	$
Unemployment- Date Ended _____	$	$
Disability	$	$
Workmen's Compensation	$	$
Child Support	$	$
Alimony	$	$
Military Income	$	$
Food Stamps	$	$
Other	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed

#6 Savings and Investments

☐ I do not have a checking account
☐ I do not have a savings account
☐ I do not have a health savings account

	Responsible Party	Spouse
Checking Account Balance	$	$
Savings Account Balance	$	$
Health Savings Account Balance	$	$
Retirement	$	$
CD/IRA/403b/401k/Annuities/IRA's	$	$
Stocks/Bonds/Interest/Life Ins./Land	$	$
Other Savings and Investments *_____	$	$
TOTAL	$	$

Use additional paper to include any other household members savings or investments not listed

#7 Other Assets

Land				$	$
	Acres		Owner/How Held	Balance Remaining	Assessed Value
Boat				$	$
	Year	Make	Model	Balance Remaining	Book Value
Camper/RV				$	$
	Year	Make	Model	Balance Remaining	Book Value
Motorcycle				$	$
	Year	Make	Model	Balance Remaining	Book Value
ATV				$	$
	Year	Make	Model	Balance Remaining	Book Value
				$	$
				TOTAL	**TOTAL**

#8 Monthly Expenses (please round to nearest dollar)

Housing

[ ] Rent payment	$
[ ] Mortgage payment	$
*Value of Home	$
Additional mortgage payment	$
*Remaining balance	$
Lot rent (mobile homes)	$
Renters insurance	$
Homeowners insurance (If not included in mortgage)	$
Property tax (If not included in mortgage)	$

Housing Utilities

Electric	$
Water	$
Gas	$
Garbage removal	$
Telephone (land line)	$
Telephone (cellular)	$
Cable and Internet	$

Transportation/Vehicles

Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Automobile payment	$
*Remaining balance	$
Year_____Make_____Model_____	
Insurance	$
Gasoline/Diesel	$

Medical

Health insurance	$
Life insurance	$
Dental insurance	$
Medications	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$
Other-_____	$
*Balance	$

#8 Monthly Expenses (continued)

Credit Cards		***Other Expenses***	
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$
Name		Type	
Payment	$	Payment	$
Balance	$	Balance	$

Miscellaneous			
Food and Paper Products	$	Child Care	$
Clothing/Shoes	$	Child Support	$
Entertainment	$	Alimony Paid	$
Charity Contributions	$	Lawn Care	$
Newspaper	$	Snow Removal	$

TOTAL EXPENSE (For Office Use Only) $ X 12 = $

#9 Other Comments

#10 Assignment of Rights

I understand that proof of income (see Financial Assistance Checklist) is required to process my application. I also understand that more information may be requested before my eligibility can be determined.

I hereby acknowledge that the information listed on this application is true and correct. If any information given proves to be untrue or is withheld I understand the hospital may take whatever action is appropriate. This action may include denial of this application up to and including denial of all future applications.

I agree that I will repay the assistance I was rewarded if I receive payment of any kind for the medical services covered by this application. Examples of this would be: insurance payments, payments from government programs, lawsuit settlements, or any other source of payment received.

Signature Date

Signature Date

Faith Regional Health Services will not grant financial assistance on procedures that are not deemed medically necessary such as; fertility testing, fertility treatment, cosmetic procedures, etc.

You must be a US Citizen, US National, or alien lawfully present in the United States in order to qualify for any type of financial assistance offered by Faith Regional Health Services

Failure to complete and/or cooperate with all other FRHS and governmental assistance programs; such as MASH, Medicaid, and/or the Healthcare Reform which began 1/1/14, disqualifies you from the financial assistance program offered by Faith Regional Health Services.

In the future if your financial situation improves and you would like to remember the assistance you received please consider making a donation to the Faith Regional Health Services Foundation.