Patient Demographics

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| Patient Name: Last, First, M. | Social Security # (If available) | Date of Birth | Account # |
| Responsible Party Name: Last, First, M. | Social Security # (If available) | Date of Birth | Relationship to Patient |
| Patient/ Responsible Party Address | County of Residence | Home Phone # | Alternate Phone # |
| City | State | Zip Code  | Homeowner? (Yes or No |
| Have you applied for Medicaid or any other State/County Assistance? (Circle one) Yes NoIf No, you must apply prior to be considered for Financial Assistance. If yes, please provide the following:Application Date: Status of Application: Caseworker Name: Caseworker Phone Number: |

Household Information

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| --- |
| Marital Status: Married Single Separated Divorced WidowedTotal Number of Dependents:  |
|  |
| Dependent Names | Relationship | Date of Birth |
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Employment / Household Income and Expenses

IMPORTANT: To qualify for assistance, include the current years Federal Tax returns and at least one piece of supporting documentation that verifies household size and income. Supporting documentation can include but is not limited to, a current W-2, 1 month of current pay-stubs, signed letter of support, etc.

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| --- | --- | --- |
| Patient or Responsible Person’s Employer Name | Pre-Tax Monthly Income: $ | Type of verification document provided: |
| If income is $0, please explain.  |
| Spouse’s Employer Name (if no spouse, write “N/A”) | Pre-Tax Monthly Income: $ | Type of verification document provided: |
| If income is $0, please explain.  |
| Other Income Source(s): | Pre-Tax Monthly Income: $ | Type of verification document provided: |
| Household Monthly Expenses  | Total Monthly Expenses: $ |  |

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING THE APPLICATION

Please be advised that your signature indicates you have agreed to attach income verification.

* I certify that the information I have provided is true and accurate to the best of my knowledge.
* I will independently or with the assistance of hospital personnel apply for ANY and ALL Assistance which may be available through federal, state, local government and private sources to help pay this healthcare bill.
* I understand that if I do not cooperate with my healthcare provider in providing requested information, my application may be denied for possible financial assistance.
* I understand that the information which I submit is subject to verification by my healthcare provider, including credit reporting agencies and subject to review by Federal and/or State agencies and others as required.
* I understand that additional information may be requested in order to qualify for assistance.

|  |  |
| --- | --- |
| Print Name and Signature (Applicant/Guarantor) | Date |

Return Completed Application and Documents to:

Nebraska Spine Hospital

Attn: Financial Assistance Department

6901 N 72nd St, 20300

Omaha, NE 68122

Phone: (402) 572-3000