FINANCIAL ASSISTANCE APPLICATION

aplicacion de lenguaje española disponibles a peticion

300 East 8th Street
Gordon, NE 69343

Due Date: _____

This application applies to charges accrued at Gordon Memorial Health Services (Hospital and Clinic). If you receive statements from other providers, please contact them to inquire about their financial assistance programs or ask if they will honor the financial assistance benefit that you received from Gordon Memorial Health Services.

****Attach the following information; without documentation your application will be denied****

- ✓ **Paycheck stub (last 30 days from employment, unemployment or workers' compensation)**
- ✓ **Current, complete statement for each account**
  - Checking-30 day statement
  - Savings-30 day statement
  - Annuities / CD
  - 401 (k)s / Retirement
  - IRAs
- ✓ **Current tax return with all schedules (most recent year filed);** if self-employed include a 6-month ledger of current income & expenses. If you did not file a tax return, please include W-2's and 1099's.
- ✓ **Verification of any additional income received by any member of the household**
  - Social Security
  - College grants and scholarships
  - Alimony/Child support
  - Pension/ retirement/ annuity/ royalty payments
  - VA benefits
  - ADC

DO NOT enclose copies of your medical/household bills

Patient/ Responsible Party Information	**Spouses Information**
Full name	Full name
Mailing address (including city, state, zip code)	Mailing address (including city, state, zip code)
Phone #	Phone #
Date of birth	Date of birth
Marital status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	Marital status (check one) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
If widowed, what is the full name of your deceased spouse_____ Spouse's date of birth _____ Date of death _____	
Employment status (check one) ☐ Full or part time ☐ Unemployed ☐ Self-employed ☐ Retired/ Disabled	Employment status (check one) ☐ Full or part time ☐ Unemployed ☐ Self-employed ☐ Retired/ Disabled
Employer (list company name and address)	Employer (list company name and address)
Gross income (before taxes/deductions) $_____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐Yearly	Gross income (before taxes/deductions) $_____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐Yearly
If unemployed, date you became unemployed_____ Date you filed for unemployment benefits_____ Do you/family currently have health insurance **Yes/No** If yes, name of company_____ Were you given the option to apply for COBRA Ins. **Yes/No**	**If unemployed,** date you became unemployed_____ Date you filed for unemployment benefits_____ Do you/family currently have health insurance **Yes/No** If yes, name of company_____ Were you given the option to apply for COBRA Ins. **Yes/No**

OTHER INCOME

If you receive Social Security for you or your dependents, unemployment, workers' compensation, child support, alimony, pensions, retirement income, VA benefits, rental income, college grants, or scholarships, list below.

Source	Amount
Source	Amount

HOUSEHOLD MEMBERS

(List all people living in your house)

Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship

CHECKING/SAVING ACCOUNTS

(List all checking and savings accounts for household members)

Bank name	Account number	Type of Account
Bank name	Account number	Type of Account
Bank name	Account number	Type of Account

OTHER ACCOUNTS

(List all 401 (k) s, IRAs, CDs, and retirement accounts for all household members)

Bank/Company Name	Account Number	Current Value
Bank/Company Name	Account Number	Current Value

VEHICLES*

(List all your vehicles. Include automobiles, boats, trailers, and recreational vehicles)

Year/ Make/ Model	Value	Monthly Payment
Year/ Make/ Model	Value	Monthly Payment
Year/ Make/ Model	Value	Monthly Payment

REAL ESTATE***

Do you own or rent? ☐ Own ☐ Rent

☐ Monthly Mortgage $_____ ☐ Monthly Rent $_____

List all real estate you own such as ranch/ farm land, rental properties and other property – **other** than your primary residence. Provide current copy of tax assessor's valuation for property. List additional property on a separate page.

Address of property	Tax assessor value	Monthly Payment
Address of property	Tax assessor value	Monthly Payment

****Disclaimer: Gordon Memorial Health Services will not take into consideration the value of automobiles, real estate, and/or other fixed assets when determining eligibility for NHSC Sliding Fee Scale. These are not required fields if only applying for Sliding Fee Scale.*

HAVE YOU APPLIED FOR ANY ASSISTANCE LISTED BELOW?

Food stamps, utility/housing assistance? Yes / No If yes, amount receiving per month $_____
Medicaid/ Kids Connection/ ADC/ Title 19/ WIC/ State or Federal Grants Yes / No If YES, date applied _____ STATUS **–circle one-** Pending / Denied / Receiving $_____ Do you have Medicaid with Share of Cost? Yes / No $_____/month
Social Security Disability/ SSI Yes / No If yes, name of person applying for benefits _____ Date applied_____ STATUS **–circle one-** Pending / Denied / Receiving $_____
Medical Cost-Sharing Program Do you participate in a medical cost-sharing program? Yes / No If YES, name the program _____

****If you need additional space, please attach an additional sheet****

Explain why you are applying for Financial Assistance from Gordon Memorial Health Services. If you have no source of income, explain how you are paying for your living expenses (rent/utilities/ food/ etc.).

_____

_____

_____

_____

_____

_____

I, the undersigned, certify that the above information is true and accurate. I understand that the information is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted or failure to provide information may jeopardize my consideration for the program. I understand that I may apply for financial assistance a total of twice within a 12 month period.

Signature of Applicant _____ **Date** _____

Signature of Spouse _____ **Date** _____

If you have any questions or wish to receive a written copy of the financial assistance policy, please contact us.

GMHS Financial Assistance
300 East 8th Street
Gordon, NE 69343

Phone (308) 282-0401
Fax (308) 282-6109
Email williamson@gordonmemorial.org

GORDON MEMORIAL HEALTH SERVICES

LEVEL II FINANCIAL ASSISTANCE

NAME _____ SPOUSE'S NAME_____

LIST ALL HOUSEHOLD MONTHLY EXPENSES

EXPENSE	MONTHLY PAYMENT	BALANCE DUE
HOME MORTGAGE / RENT		
CAR PAYMENT		
CAR PAYMENT		
CREDIT CARD #1		
CREDIT CARD #2		
CREDIT CARD #3		
CREDIT CARD #4		
HOME / RENTERS INSURANCE		
GAS / PROPANE		
ELECTRICITY		
WATER / GARBAGE		
TELEPHONE		
CELL PHONE		
CABLE		
INTERNET		
HEALTH INSURANCE		
FUEL (GAS / DIESEL)		
CAR INSURANCE		
DAY CARE		
SCHOOL LUNCHES		
GROCERIES		
MEDICATIONS		
HOSPITAL BALANCES & LOCATIONS		
OTHER MEDICAL SERVICES		
MISCELLANEOUS (PLEASE SPECIFY)		