



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 Hospital District (Hospital and both Clinics). 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 Hospital District.

****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) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Marital status (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> 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) <input type="checkbox"/> Full or part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired/ Disabled	Employment status (check one) <input type="checkbox"/> Full or part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired/ Disabled
Employer (list company name and address) _____	Employer (list company name and address) _____
Gross income (before taxes/deductions) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Gross income (before taxes/deductions) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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/ farmland, 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 Hospital District 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 Hospital District. 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 once 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.

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

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