HENDERSON HEALTH CARE SERVICES, INC.

1621 Front Street Henderson NE 68371 Phone 402.723.4512 Fax 402.723.4520

MEDICAL FINANCIAL ASSISTANCE APPLICATION

Applicant

Name_____ Account number_____
First MI Last

Address_____ Phone number ( ) _____
Mailing City/State Zip

Number of years at this address _____ ___Own ___Renting

Date of birth_____ Male___ Female___ Social Security #_____

Marital Status ___ Married ___Separated ___Divorced ___Widow ___Single

Employer name_____ Employer phone #_____

Employer address_____ Position/Title _____

Spouse

Name_____
First MI Last

Date of birth_____ Male___ Female___ Social Security #_____

Employer name_____ Employer phone #_____

Employer address_____ Position/Title _____

Number of family members living with you_____ (if more than five list on back)

Name	Birth date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Monthly Income			
	Applicant	Spouse & Other Household Members	Total
Gross Monthly Earnings	$	$	$
Farm/Self Employed			
Pensions			
Work Comp			
Interest			
Dividends			
Rental Income			
Disability/SSI			
Military			
Child Support			
Alimony			
Unemployment Compensation			
ADC/Food Stamps			
State Assistance			
Other			
		Total Monthly Income	$

Amount of medical services requesting financial assistance with $_____

Type of medical service received_____

Date(s) of service(s)_____

Episode/Bill No(s) _____

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services rendered to me by Henderson Health Care Services, Inc. ("HHC"). I also understand that if the information which I submit is determined by HHC to be false, significantly inaccurate, or incomplete, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for services provided. I understand that if I do not qualify for uncompensated services, I will be personally liable for the charges of the services rendered or I may appeal decision in writing with additional documentation.

I have attached my two years most recent signed Federal Income Tax Returns, three months most recent pay stubs for members of my household, three months most recent bank statements for all bank accounts for all members of my household, and W-2 forms for the two most recent years for members of my household. I understand that I may be asked to further verify income during the processing of this application. I understand that a requirement of applying for financial assistance from HHC is exhaust all other insurance coverage including Medicaid, therefore I have applied for Medicaid and have attached my determination letter dated within 30 days of this application.

I hereby grant permission to those HHC personnel who are authorized to receive, release or act upon financial information contained herein. I hereby release the designated HHC personnel and all parties who supply information at the request of the HHC personnel, from liability for any acts, communications and disclosures which are made pursuant to such an investigation.

_____ _____

Applicant Signature Date

_____ _____

Spouse Signature Date

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(For office use only)

Date Application Received by HHC:_____

Income Verified: YES_____ NO_____

Type of Verification: _____

☐ Approved Amount provided as uncompensated service is $_____.
☐ Denied The request has been denied for reasons that include but may not be limited to:
_____

☐ Applicant Notified Date:_____

Approved by: _____ Date:_____

_____

Calculation of household income and eligible financial assistance (office use only):