☐ **Bryan Medical Center**
Patient Financial Services
2300 S. 16th St.
Lincoln, NE 68502-9907
402-481-5791 or
1-877-577-9277

☐ **Bryan Physician Network**
2221 S. 17th St., Suite 401
Lincoln, NE 68502
402-483-8590

☐ **Bryan Heart**
P.O. Box 82653
Lincoln, NE 68501
866-895-5612

☐ **Crete Area Medical Center**
2910 Betten Dr.
Crete, NE 68333
402-826-6588
866-362-2262

☐ **Merrick Medical Center**
1715 26th St.
Central City, NE 68826
308-946-3015

Financial Assistance Application Form

Patient Name(s): _____ **Medical Record Number(s):** _____

GUARANTOR	SPOUSE
Name Date of Birth	Name Date of Birth
Social Security Number Home Phone Business Phone	Social Security Number Home Phone Business Phone
Present address No. years:_____ ❑ Own ❑ Buying ❑ Rent	Present address No. years:_____ ❑ Own ❑ Buying ❑ Rent
Street: _____	Street: _____
City/State/Zip: _____	City/State/Zip: _____
Former address if less than 2 years at present address	Former address if less than 2 years at present address
Street: _____	Street: _____
City/State/Zip: _____	City/State/Zip: _____
Marital status: ❑ Married ❑ Separated ❑ Divorced ❑ Widow ❑ Single	Marital status: ❑ Married ❑ Separated ❑ Divorced ❑ Widow ❑ Single
Total number residing in household: _____	Total number residing in household: _____
Number of dependent children: _____ Ages: _____	Number of dependent children: _____ Ages: _____
Name and address of employer	Name and address of employer
Position/Title: _____ Length of employment: _____	Position/Title: _____ Length of employment: _____
Previous employer(s) (within the last year)	Previous employer(s) (within the last year)

Supporting documentation is required for all responsible parties. Please provide copies of the documents listed below. Your application cannot be processed until these items are received. If you have no proof of income or no income, please include an additional page with an explanation.

- **Federal Tax Return** for the last tax year and the year in which services were provided. If the tax return for the current year has not been filed, use last tax year.
- **Proof of income** for the current year and the year in which services were provided. Sources of income may include pay stubs, unemployment or disability checks, Social Security award letters and/or a pension letter.
- **Bank statement** including all transactions.

MONTHLY INCOME

	Guarantor	Co-applicant	Total
Gross earnings	$	$	$
Farm/Self employed			
Pensions			
Work compensation			
Interest/dividends			
Rental property income			
Disability/SSI			
Military income			
Child support			
Alimony			
Unemployment			
ADC/Food stamps			
Subsidized housing			
Total monthly household income:			

MONTHLY HOUSEHOLD EXPENSES

Mortgage/rent payment (Circle one)	$	Child care expense	$
Lot rent		Child support payment	
Federal withholding taxes: # Exemptions_____		Credit cards (Minimum payment)	
State withholding taxes		Other loan(s) payment	
401K/403B withholding		Meds/med. supplies	
Property taxes		Auto loan payment	
Utilities, telephone/cell phone, insurance premiums		Alimony payment	
Garbage pickup		Other	
Cable TV			
Food			
Total monthly household expenses:			$

ASSETS		LIABILITIES	
Description	**Cash totals or market value**	**Description**	**Total owed**
Cash	$	Mortgage loans	$
Checking accounts	$	Name of financial institution:	
Name of financial institution:		Home owners insurance	
Savings accounts	$	If not included in mortgage	
Name of financial institution:		Auto loan	
Life insurance net cash/loan value		Vehicle licensing tax	
Real estate property assessed value		Credit cards	
Net worth of farm or business (attach business tax return)		List other loans and locations	
Retirement funds			
• Pensions/Annuity			
• IRAs/401K			
• Mutuals			
• Other			
Automobiles (make and year)		List medical co-pay/out of pocket expenses and/or patient responsibility	
Other assets (boats, motorcycles, campers and antiques) Blue Book/retail		Other:	
Total Assets	**$**	**Total Liabilities**	**$**

FEDERAL/STATE ASSISTANCE PROGRAMS

Have you applied for any federal or state program that would assist with your medical expenses at Bryan Medical Center, Bryan Physician Network, Bryan Heart, Crete Area Medical Center or Merrick Medical Center? Yes_____ No_____

If yes, please provide documentation of the determination.

Are you currently pending final determination? If so, please provide the following information:

Program name Application date Case worker County telephone #

_____

_____

HEALTH COVERAGE INFORMATION

Is health insurance coverage available to you through an employer or any other source? Yes_____ No_____

Do you participate? Yes_____ No_____

- If yes, please provide the following: Effective date: _____

Name of the insurance company: _____

Address: _____

Subscriber and policy number: _____

- If no, why did you choose not to participate: _____

_____

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 Bryan Medical Center, Bryan Physician Network, Bryan Heart, Crete Area Medical Center or Merrick Medical Center. I also understand that if the information, which I submit is determined to be false, such a determination will result in a denial of providing services such as uncompensated services, and that I will be liable for charges for services provided.

IN YOUR OWN WORDS, DESCRIBE YOUR NEED FOR FINANCIAL ASSISTANCE

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

_____ _____

Signature (person making request) Date