



Financial Assistance Application Form

Patient Name(s): _____ **Guarantor 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: _____ <input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> Rent			Present address No. years: _____ <input type="checkbox"/> Own <input type="checkbox"/> Buying <input type="checkbox"/> 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:* <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> Single			Marital status:* <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/> 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 last 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			MONTHLY HOUSEHOLD EXPENSES				
	Guarantor	Co-applicant	Total		\$		\$
Gross earnings	\$	\$	\$	Mortgage/rent payment (Circle one)		Child care expense	
Farm/Self employed				Lot rent		Child support payment	
Pensions				Federal withholding taxes: # Exemptions _____		Credit cards (Minimum payment)	
Work compensation				State withholding taxes		Other loan(s) payment	
Interest/dividends				401K/403B withholding		Meds/med. supplies	
Rental property income				Property taxes		Auto loan payment	
Disability/SSI				Utilities, telephone/cell phone, insurance premiums		Alimony payment	
Military income				Garbage pickup		Other	
Child support				Cable TV			
Alimony				Food			
Unemployment							
ADC/Food stamps							
Subsidized housing							
Total monthly household income:				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	\$

Central City Medical Clinic and Fullerton Medical Clinic Patients - starred () items are optional. Assets, social security number, citizenship status, housing status and/or mental status are not considered when determining eligibility for the sliding fee discount program.

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

For Questions or to Return this Application:

Bryan Health
 Patient Financial Services
 2300 S. 16th St.
 Lincoln, NE 68502-9907
 Phone: 402-481-5791 or 1-877-577-9277
 Fax: 402-481-5721
 Email: PFS@bryanhealth.org

For Bryan Health Office Use Only

BEES Patient	
Medicaid Approved?	
If Denied, Why?	
FPL	