 **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 bank/credit union/ investment account statement for each account**
* Checking/Debit -30 day statement
* Pension/Retirement
* Stocks/Bonds
* Savings- 30 day statement
* Annuities/Cert. of Deposit
* Keogh Accounts
* Health/Medical Savings Account
* 401 (k)s/Investments
* 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/SAVINGS & DEBIT CARD ACCOUNTS**

(List all checking/savings and debit card 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, annuities, stocks, bonds, Keogh 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 |

**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\*\***

**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 | Estimated equity | Monthly Payment |
| Address of property | Tax assessor value | Estimated equity | Monthly Payment |

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.

**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 (FAST)  300 East 8th Street  Gordon, NE 69343 | Phone (308) 282-0401  Fax (308) 282-6109  Email dmacumber@gordonmemorial.org |