

Providence Medical Center-Wayne

Financial Assistance Application

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Financial Statement

Providence Medical Center is pleased to offer financial assistance to our patients. Please complete this financial statement and return it, along with your most recent IRS & state tax return, W-2, last pay stub, and copies of your bank statements for the past three months to the Patient Accounts Department. Failure to complete and return this application, and provide all pertinent information may result in non-coverage or rejection.

**This must be returned within ten (10) business days, no later than ___/___/___.
You will be notified of our determination within thirty (30) days from the date of receipt of your completed application.**

1200 Providence Road · Wayne, Nebraska 68787 · (402) 375-3800

APPLICANT INFORMATION:

Name: _____ Social Security No.: _____
Street Address: _____ Birth Date: _____
City/State/Zip: _____ Sex: male / female (circle one)
Telephone: _____ Race (optional) _____

Marital Status: Single Married Divorced Widowed Separated (circle one)
Spouse Name: _____ Social Security No: _____

Applicant Education (years): 8 9 10 11 12 13 14 15 16 17 18 19 20
Spouse Education (years) 8 9 10 11 12 13 14 15 16 17 18 19 20

DEPENDENTS: I am responsible for support of the following individuals (include spouse):

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

EMPLOYMENT:	Self	Spouse
Name of Employer:	_____	_____
Employer's Phone:	_____	_____
Length of Employment:	_____ years _____ months	_____ years _____ months
Occupation:	_____	_____

If not employed are you: Retired Unemployed Not in Labor Force (please circle one)

MONTHLY INCOME:	Self	Spouse
Employment (gross pay)	\$ _____	\$ _____
Part time jobs:	\$ _____	\$ _____
Social Security:	\$ _____	\$ _____
Pensions:	\$ _____	\$ _____
Unemployment Benefits:	\$ _____	\$ _____
Worker's Compensation	\$ _____	\$ _____
Union Benefits:	\$ _____	\$ _____
Investment Income:	\$ _____	\$ _____
Rentals:	\$ _____	\$ _____
Child Support:	\$ _____	\$ _____
Food Stamps:	\$ _____	\$ _____
ADC:	\$ _____	\$ _____
Welfare:	\$ _____	\$ _____
Other	\$ _____	\$ _____
Inheritance / Trusts:	\$ _____	\$ _____
Total Monthly Income:	\$ _____	\$ _____

MONTHLY EXPENSES:

Monthly Payment

Rent / Mortgage (circle one)	\$ _____
Food	\$ _____
Utilities (gas, electricity, water)	\$ _____
Auto Gas and Repairs	\$ _____
Telephone	\$ _____
Insurance, Home	\$ _____
Insurance, Medical	\$ _____
Insurance, Car	\$ _____
Insurance, Life	\$ _____
Insurance, Other _____	\$ _____
Child Care	\$ _____
Property Taxes	\$ _____
Other, _____	\$ _____
Other, _____	\$ _____

Repayment of Debt:

Monthly Payment

Unpaid Balance

<u>Institution Name</u>		
Loan _____	\$ _____	\$ _____
Loan _____	\$ _____	\$ _____
Loan _____	\$ _____	\$ _____
Visa _____	\$ _____	\$ _____
MasterCard _____	\$ _____	\$ _____
Other Credit Card _____	\$ _____	\$ _____
Other Credit Card _____	\$ _____	\$ _____
Other Credit Card _____	\$ _____	\$ _____
Mortgage _____	\$ _____	\$ _____

Medical Debt:

Facility/Dr. Name

Hospital _____	\$ _____	\$ _____
Hospital _____	\$ _____	\$ _____
Doctor _____	\$ _____	\$ _____
Doctor _____	\$ _____	\$ _____
Doctor _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____
Other _____	\$ _____	\$ _____

Total Monthly Payments	\$ _____	\$ _____
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BANKING INFORMATION:

Bank Name: _____ Address: _____
 City: _____ State: _____ Zip: _____

Checking Account Number: _____ Balance: \$ _____
 Saving Account Number: _____ Balance: \$ _____
 Certificate of Deposit: _____ Balance: \$ _____
 Other Balance: _____ Balance: \$ _____
 Other Investments / Securities: _____ Balance: \$ _____

Total \$ _____

PROPERTY / OTHER ASSETS: Estimated Value Unpaid Balance

Residence: \$ _____ \$ _____
 Name of mortgage firm: _____
 Vehicle 1, yr/model: _____ \$ _____ \$ _____
 Vehicle 2, yr/model: _____ \$ _____ \$ _____
 Vehicle 3, yr/model: _____ \$ _____ \$ _____
 Farm Land: _____ \$ _____ \$ _____
 Business: _____ \$ _____ \$ _____
 Rental Property: _____ \$ _____ \$ _____
 Other: _____ \$ _____ \$ _____

OTHER INFORMATION THAT YOU FEEL IS IMPORTANT:

	<i>Yes</i>	<i>No</i>	<i>Outcome</i>
I have applied for Title XIX benefits:	_____	_____	_____
I have applied for Social Security benefits:	_____	_____	_____
I have applied for Disability benefits:	_____	_____	_____

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services provided by Providence Medical Center.

I hereby grant permission to Providence Medical Center to verify information contained herein.

Applicant's Signature: _____ Date: _____