Sidney Regional MEDICAL CENTER

Financial Application

If you have questions while filling out this application, please contact a Patient Account Specialist at 308.254.8778. Once your application has been received, a Patient Account Specialist will contact you regarding your qualification.

All answers should be for the entire household.

Who is the guarantor of the patient?

Names of patients listed for this guarantor:

Is the guarantor or patient on Medicare?

- [ ] Yes
- [ ] No

Does the patient meet NE Medicaid eligibility?

- [ ] Yes
- [ ] No

1) 65 years of age or older.

2) An individual under 65 years of age who has a disability or is visually imparted according to Social Security guidelines. If possibly disabled, patient should apply for disability and Medicaid prior to receiveing charity care. (Patients will provide case numbers for each application.)

3) An individual 19 years of age or younger.

4) A dependent child who meets the eligibility requirements of the Aid to Dependent Children Program.

If you answered yes to the previous question, have you or the patient applied?

- [ ] Yes
- [ ] No

If Yes, please provide the date you applied and the case number.

Once you have completied the Charity Care application, please understand that a determination of Charity Care eligibility will not be made until the denial letter from Medicaid is received by one of our Patient Account Specialists.

Select one of the following ways to apply:

1) Phone at 855.632.7633

2) Online at http://http://dhhs.ne.gov/children_family_services/accessnebraska/Pages/accessnebraska_index.aspx (http://dhhs.ne.gov/children_family_services/accessnebraska/Pages/accessnebraska_index.aspx)

3) In person at your local Department of Health and Human Services.

If you or the patient were denied coverage through, NE Medicaid, please attach denial letter.

How many people live primarily in the household?

What is the combined annual income of all peole who live primarily in the household?

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By submitting this application, I certify that the information provided is as complete and true to the best of my ability. I also understand that if I make false statements on this application, any adjustment I receive from the SRMC Charity Care Program could be withheld and/or reversed at a future date. I authorize SRMC to use any information contained in the application to verify my eligibility for adjustment from SRMC Charity Care Program, and to obtain records pertaining to eligibility from a financial instituion as defined in Section 15-15-201(4), C.R.S. or from any insurance company.

I understand that SRMC has the right to obtain any recovery or right of recovery for a patient who would have has a right of recovery. This means that if I am found to have a claim for any benefits payable for any treatment, which is given while I am eligibly for the SRMC Charity Care Program, that SRMC has the right to be included in the claims process. I also understand that should I faile to keep any payment arrangements made with SRMC on the ramaining balance fo my account(s), any adjustment received may be reversed and my account(s) will be sent to any external collection agency.

Liabilities- Obligations

For Charity Care - Information for Entire Household

LIST ALL PERSONAL, TRUST PARTNERSHIP, OR CORPORATE DEBTS. INCLUDE RENT, DEBTS FOR 1ST AND 2ND LIEN LOANS (MORTGAGE OR TRUST DEED), SRMC DEBT. AUTOS, APPLIANCES, FURNITURE, PERSONAL LOANS AND NOTES, CO-SIGNED NOTES, GARNISHMENTS/JUDGEMENTS, AND CREDIT CARD/CHARGE ACCOUNTS.

Debt 1 Owed to:

Debt 1 Monthly Payment:

Debt 1 Balance:

Debt 1:

- [ ] Applicant
- [ ] Co-Applicant

Debt 2 Owed to:

Debt 2 Monthly Payment:

Debt 2 Balance:

Debt 2:

- [ ] Applicant
- [ ] Co-Applicant

Debt 3 Owed to:

Debt 3 Monthly Balance:

Debt 3 Balance:

Debt 3:

- [ ] Applicant
- [ ] Co-Applicant

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Debt 4 Owed to:

Debt 4 Monthly Payment:

Debt 4 Balance:

Debt 4:

- [ ] Applicant
- [ ] Co-Applicant

Debt 5 Owed to:

Debt 5 Monthly Payment:

Debt 5 Balance:

Debt 5:

- [ ] Applicant
- [ ] Co-Applicant

Debt 6 Owed to:

Debt 6 Monthly Payment:

Debt 6 Balance:

Debt 6:

- [ ] Applicant
- [ ] Co-Applicant

Debt Total Monthly Payment:

Debt Total Balance:

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What is the combined Annual Gross Income of all people who live primarily in the household?

Application should be submitted with the following supporting documentation include current year W-2's, tax return, unemployment statement and may include a Medicaid denial letter, if applicable. If W-2's are not applicable or taxes were not filed, submit the last three months of most current pay stubs.

Attach Proof of Income

How much of this income is derived from a full-time college or high school student(s)?

Do you or anyone in the household own a home?

- ☐ Yes
- ☐ No
- ☐ Rent

Assessed value of real estate owned & balance owed on mortgages secured by the real estate (if property is located outside Cheyenne County include address):

Net worth of Business Owned

Amount owned against the Business

Attach Current Business Financial Statement

Other property (vehicles/boats/motorcycles/etc.) owned by anyone living in the household:

Value of other investments (including: retirement, stocks, bonds, property, etc.):

Does anyone living in the house hold pay or receive Alimony?

- ○ No Alimony
- ○ Pay Alimony
- ○ Receive Alimony

Alimony Amount Received:

Alimony Amount Paid:

Current monthly payment to SRMC or Physicians Clinic for prior medical expenses?

How many months are remaining for that payment?