

In order for us to evaluate the solution that best fits your financial situation, please complete the below questions to determine our next steps.

# This application must be returned within 30 days.

Please contact us with any questions or concerns you may have at 308-254-8778. We are here to help.

~YOUR PATIENT ACCOUNT SPECIALIST TEAM

#### **SECTION I**

Check if this applies to you:

☐ Ages 19 through 64 and meet the following income criteria:

Household Size	Annual Income is Less Than
1	20,030
2	27,185
3	34,341
4	41,496
5	48,651

Household Size	Annual Income is Less Than
6	55,807
7	62,962
8	70,118
9	75,498
10	80,878

<sup>\*</sup>Effective 1/1/24 - Subject to Change

## If you checked the above box, SKIP TO APPLY FOR MEDICAID SECTION III. If not, continue to Section II.

SECTION II
Check any that apply to you:
$\square$ 65 years or older
☐ Under 65 and have a disability or visually impaired, according to Social Security Guidelines
☐ 18 years or younger
☐ A pregnant woman
☐ A parent or caretaker
$\square$ A former foster care youth (no income criteria) between ages 19-25, active on Medicaid at the time they aged out,
and was in Nebraska foster care.
$\square$ Medically frail health condition. Meeting any of the following criteria: Disabling mental health condition; a chronic
substance use disorder; a physical, intellectual, or developmental disability with functional impairment that signifi-
cantly impairs an individual from performing one or more activities of daily living each time the activity occurs; a
disability determination based on Social Security Criteria; a serious and complex medical condition; or chronically
homeless as defined by the United States Department of Housing and Urban Development.

If you checked any of the above boxes, CONTINUE TO THE APPLY FOR MEDICAID SECTION III AND COMPLETE SECTION IV.



### **SECTION III**

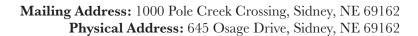
### APPLY FOR MEDICAID

- Apply online at www.ACCESSNebraska.ne.gov
- Apply over the phone by calling ACCESS Nebraska at
  - \* Omaha: (402) 595-1178
  - \* Lincoln: (402) 473-7000
  - \* Toll Free: (855) 632-7633
  - \* TDD: (402) 471-7256
- Apply by paper application (which may be downloaded from AccessNebraska.gov)
  - \* Faxed to (402) 742-2351
  - ♦ E-mailed at <u>DHHS.ANDICenter@nebraska.gov</u>
  - \*Sent by mail to P.O. Box 2992, Omaha, NE 68103-2992
- Apply in-person at a DHHS local office. Find a local office at http://dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx

### **SECTION IV**

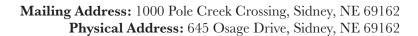
Please complete the application and provide the following documents for your household

- COPY OF MOST RECENT INCOME TAX RETURN –
   Federal & State (for all members living in your household) OR
- COPIES OF PREVIOUS THREE MONTHS PAY STUBS
- IF YOU RELY ON SOCIAL SECURITY FOR YOUR INCOME, PLEASE PROVIDE A COPY OF YOUR ANNUAL DISBURSEMENT LETTER



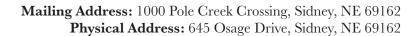


SRMC Financial Assistance Application									
Household Information (for patient or guarantor if patient is a minor)									
FULL NAME (Last, F	First, Middle Initial)			E-mail Address					
		Ent	er for everyone l	living in your ho	ome.				
Household Members	Relationship to Guarantor	Gross Income	Child Support Paid	Child Support Received	Date of Birth	Disabled (Circle one) Full-Tim Student (Circle or		dent	
						Υ	N	Υ	N
						Υ	N	Y	N
						Υ	N	Υ	N
						Υ	N	Υ	N
						Υ	N	Υ	N
						Y	N	Υ	N
						Υ	N	Υ	N
			Personal Ir	nformation					
	Applicant (	Guarantor)		CO-APPLIC	ANT (for Extend	ded Fina	anced o	ptions o	only)
FULL NAME (Last, F	irst, Middle Initial)			FULL NAME (Last,	First, Middle Initial)				
PRESENT PHYSICAL ADDRESS / CITY / STATE / ZIP			PRESENT PHYSICAL ADDRESS / CITY / STATE / ZIP						
Married Dunmarried Separated			Married Unmarried Separated					ted	
			Employment	Information					
NAME AND ADDRES	SS OF EMPLOYER	YEARS OR M	MONTHS WORKED	NAME AND ADDRE	SS OF EMPLOYER	YE	ARS OR M	ONTHS W	ORKED
PHONE NUMBER		JOB TITLE		PHONE NUMBER		JOB TITI	LE		



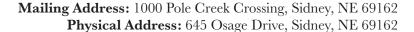


Income								
Applicant (Guarantor)			CO-APPLICANT (for Extended Financed options only)					
	ual Income Any Other)			Gross Annual Income (Salary & Any Other)				
	ort/Alimony eived			Child Support/Alimony Received				
	support/ ny Paid			Child Support/ Alimony Paid				
TOTAL I	NCOME			TOTAL INCOME				
Investments								
	Applicant (	Guarantor)		CO-APPLIC	ANT (for Extend	ded Financed o	ptions only)	
Туре	Value	Amount of Debt Secured by Investment		Туре	Value	Amount of Debt Secured by Investment		
Savings	\$			Savings	\$			
Retirement/ 401k	\$			Retirement/ 401k	\$			
Stocks	\$			Stocks	\$			
Bonds	\$			Bonds	\$			
Investment Property	\$			Investment Property	\$			
Other	\$			Other	\$			
TOTAL	\$			TOTAL	\$			
Property								
					Co-Applicant			
,				rty: \$				
financial			Amount Owne	d ess: <b>\$</b>				





Property (continued)						
Vehicles, Boats, Motorcycles, etc.						
Year	Make/Model	Value	Amount Owned Against Property	Applicant	Co-Applicant	
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
	TOTAL	\$				
		Liabilities-Obligations		Applicant	Co-Applicant	
	L PERSONAL, TRUST PARTNERSHIPS O (MORTGAGE OR TRUST DEED), AUTOS, NOTES, GARNISHMENTS/JUI	APPLIANCES, FURNITU	IRE, PERSONAL LOANS AT	ND NOTES, C		
	Owed to	Monthly Payment	Balance	Applicant	Co-Applicant	
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
	TOTAL	\$				





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

Accepted:	
Applicant:	Date:
Co-Applicant:	Date: