BOX BUTTE GENERAL HOSPITAL

Patient Financial Services
PO Box 810
Alliance NE 69301
ph: 308.762.6660

APPLICATION FOR FINANCIAL ASSISTANCE - PERSONAL INFORMATION

Patient Name: ______________________ Birth Date: ______________
Address: ______________________ Phone (home): ______________
______________________ Phone (work): ______________
Phone (cell): ______________

Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed ___ Legally Separated

Spouse Name: ______________________ Birth Date: ______________
Address (if different): ______________________ Phone (home): ______________
______________________ Phone (work): ______________
Phone (cell): ______________

Dependents:

Name: __________________ Age: _____ Relationship: _______________ Cell Phone: ______________
Name: __________________ Age: _____ Relationship: _______________ Cell Phone: ______________
Name: __________________ Age: _____ Relationship: _______________ Cell Phone: ______________
Name: __________________ Age: _____ Relationship: _______________ Cell Phone: ______________

Patient Employer:

Name: ______________________
Address: ______________________
____
Phone: ______________________
How long employed: _________
Full Time ___ Part Time ___
Health Insurance? ___ Yes ___ No
Retirement Plan? ___ Yes ___ No
Monthly Gross Wages: $_______________
If not currently employed, last date of employment _________________

Spouse Employer:

Name: ______________________
Address: ______________________
____
Phone: ______________________
How long employed: _________
Full Time ___ Part Time ___
Health Insurance? ___ Yes ___ No
Retirement Plan? ___ Yes ___ No
Monthly Gross Wages: $_______________
If not currently employed, last date of employment _________________

If you report zero income, please submit a signed statement explaining how your daily living expenses are being covered and by whom.

Any other income? (Alimony, child support, disability, social security, pension, etc.)

Patient: ___ Yes ___ No If Yes, income per month $__________ and Source ______________
Spouse: ___ Yes ___ No If Yes, income per month $__________ and Source ______________
Do you receive food stamps, utility or housing assistance? ___ No ___ Yes Amount $_______________
Have you filed for bankruptcy? ___ No ___ Yes Case #___________________

APPLICATION FOR FINANCIAL ASSISTANCE - LIVING EXPENSES

Rent - or -: $__________ per month
House Pymt: $__________ per month
Utilities: $__________ per month
Television: $__________ per month
Internet: $__________ per month
Telephone: $__________ per month
Cell Phone(s): $__________ per month

Food: $__________ per month
Clothing: $__________ per month
Insurance: $__________ per month
Vehicle Gas/Repairs: $__________ per month
Car Payments: $__________ per month
Doctor/Dentist Bills: $__________ per month
Hospital Bills: $__________ per month

Other (explain)
__________________ $__________ per month
__________________ $__________ per month
__________________ $__________ per month
__________________ $__________ per month

Are any of these expenses shared by a housemate that is not a spouse or dependent? ________

APPLICATION FOR FINANCIAL ASSISTANCE - PERSONAL ASSETS AND LIABILITIES

Values are as of what date?: ______________

Personal (Non-Business) Assets and Liabilities:

Checking Accts: $___________
Savings Accts: $___________
IRA Accts: $___________
Health Savings Accts: $___________
Investments: $___________
CDs: $___________
Life Insurance Cash Surrender Value: $___________

Home Value: $___________
Vehicles: $___________
Motorcyles: $___________
RVs: $___________
Boats/Trailers: $___________
Other ______________: $___________
Other ______________: $___________
Other ______________: $___________

Vehicles: Year ___________ Make _______________ Year ___________ Make _______________
Value $_________ Amt Owed $___________ Value $_________ Amt Owed $___________

Year ___________ Make _______________ Year ___________ Make _______________
Value $_________ Amt Owed $___________ Value $_________ Amt Owed $___________

Home: Value $____________ Amount Owed $____________

Credit Cards: Card Name ____________________ Balance Owed $_________ Monthly Pymt $_______
Card Name ____________________ Balance Owed $_________ Monthly Pymt $_______
Card Name ____________________ Balance Owed $_________ Monthly Pymt $_______
Card Name ____________________ Balance Owed $_________ Monthly Pymt $_______

Other Loans: Description ____________________ Balance Owed $_________ Monthly Pymt $_______
Description ____________________ Balance Owed $_________ Monthly Pymt $_______

APPLICATION FOR FINANCIAL ASSISTANCE - FARMER, RANCHER, BUSINESS OWNER

Business Owner Includes Owners of Rental Property

Check if you are **NOT** a farmer, rancher or business owner: ☐

Values are as of what date?: ______________ Name of business: _____________________________

Business Assets:

Cash in bank	$______________	at actual balance
Investments	$______________	at market value
Accounts receivable	$______________	at collectible value
Inventory	$______________	at cost
Stored crops	$______________	at market value
Livestock*	$______________	at market value
Land*	$______________	at market value
Buildings*	$______________	at market value
Equipment*	$______________	at market value
Vehicles*	$______________	at market value
Other assets	$______________	describe ______________
Other assets	$______________	describe ______________
Other assets	$______________	describe ______________
Other assets	$______________	describe ______________
Total Assets	$	

Business Liabilities:

Loan Payable	$______________	describe ______________
Loan Payable	$______________	describe ______________
Loan Payable	$______________	describe ______________
Credit Card Payable	$______________	describe ______________
Credit Card Payable	$______________	describe ______________
Accounts Payable	$______________	
Salaries Payable	$______________	
Payroll Taxes Payable	$______________	
Real Estate Taxes Due	$______________	
Interest Payable	$______________	
Other Liabilities	$______________	describe ______________
Other Liabilities	$______________	describe ______________
Total Liabilities	$	
Assets minus Liabilities	$	= Net Business Value

* Include a detailed schedule of business assets. A complete depreciation schedule disclosing all business assets will satisfy this requirement.

Attach additional pages as needed. You may substitute a financial statement prepared by an accountant.
If an accountant prepared statement is used please complete the following:

Name/Address of accounting firm: ____

APPLICATION FOR FINANCIAL ASSISTANCE - SUPPORTING DOCUMENTATION

Include the following information. Without this documentation your application will be denied.

- [ ] Paycheck stubs - last 60 days from employer, unemployment or workers' compensation for all members of household.

- [ ] Current and complete bank, credit union, investment account statements, and life insurance cash surrender value statements.
  - [ ] Checking
  - [ ] Pension/retirement
  - [ ] Stocks/Bonds
  - [ ] Savings
  - [ ] IRAs/401Ks/403Bs
  - [ ] Life Insurance Statement
  - [ ] CDs (certificates of deposit)
  - [ ] Annuities

- [ ] Complete tax returns for the last 2 years. (If self-employed, include complete depreciation schedules.)

- [ ] Documentation of any additional income received by any member of the household
  - [ ] Social Security
  - [ ] ADC/WIC
  - [ ] Pension/retirement/annuity
  - [ ] Alimony/Child Support
  - [ ] VA benefits
  - [ ] Housing/Utility assistance
  - [ ] Disability
  - [ ] College grants/scholarships

- [ ] Copies of applicant's outstanding medical bills from all providers.

APPLICATION FOR FINANCIAL ASSISTANCE - ATTESTATION

I hereby submit this information for the purpose of allowing Box Butte General Hospital to evaluate my financial status to determine my eligibility for various financial assistance programs. I authorize BBGH to verify this information which may include a credit bureau report, employment and/or income verification and appropriate supporting documents.

I attest that the information and all documentation provided are complete and accurate as shown. I realize that should any of this information prove to be false, all financial assistance will be denied and I will accept responsibility for full and immediate payment of any and all outstanding balances. The financial assistance granted from the date of the application will remain valid for 90 days and will apply to any other accounts during this time ***excluding elective procedures***. Accounts that have had legal action or garnishment judgments are not eligible for financial assistance.

By applying for financial assistance, I also agree to accept payment responsibility for any amount due from me as a result of any financial assistance which may be awarded. Financial assistance will not be considered for accounts totaling less than $500.00.

I authorize BBGH to contact me using any or all of the following methods:

Patient:	Spouse:
☐ Home telephone __________________	☐ Home telephone __________________
☐ Work telephone __________________	☐ Work telephone __________________
☐ Cell phone ______________________	☐ Cell phone ______________________

Signature of Patient ______________________________________ **Date** ____________________

Signature of Spouse ______________________________________ **Date** ____________________