
## APPLICATION FOR FINANCIAL ASSISTANCE

### PERSONAL INFORMATION:

Patient Name: _____ Birth Date_____

Address: _____ Phone: _____

_____ Cell: _____

Marital Status: ___Single ___Married ___Divorced ___Widowed

Spouse Name: _____ Birth Date_____

Address: _____ Phone: _____

_____ Cell: _____

### DEPENDENTS:

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

Name: _____ Age: _____ Relationship_____

### 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: _____

**REPORTED INCOME: (WAGES, 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? ____Yes ____No Amount $_____

Have you filed for Bankruptcy? ____Yes ____No Case #_____

**IF YOU REPORT ZERO INCOME, PLEASE SUBMIT A SIGNED STATEMENT EXPLAINING HOW YOUR DAILY LIVING EXPENSES ARE BEING COVERED AND BY WHOM.**

**Personal/Business Assets:**

Checking Accts $: _____ Savings Accts $: _____

Retirement Accts $: _____ HSA Accts $: _____

Investments $: _____ CD's $:_____

Cash Value Life Ins $: _____ Other $: _____

**APPLICATION FOR FINANCIAL ASSISTANCE – FARMER, RANCHER, BUSINESS OWNER**

Values are as of what date?:_____ Name of Business: _____

**Business Assets:**

Cash$:_____ at actual balance

Investments$:_____ at actual balance

Accounts Receivable$:_____ at actual balance

Inventory$:_____ at cost

Stored crops$:_____ at market value

Livestock$:_____ at market value

Land/other RE$:_____ at market value

Equipment$:_____ at market value

Vehicles$:_____ at market value

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 $:_____ RE Taxes Due$:_____

Other Liabilities $:_____ Other Liabilities $:_____

**Total Liabilities$:_____ Net Worth$:_____**

****You may substitute a current Financial Statement prepared by your bank or accountant****

## APPLICATION FOR FINANCIAL ASSISTANCE – SUPPORTING DOCUMENTATION

***INCLUDE THE FOLLOWING INFORMATION. WITHOUT THIS DOCUMENTATION, YOUR APPLICATION WILL BE DENIED.***

**O** Paycheck stubs – 60 days from employer, unemployment, or worker's compensation for all members of household

**O** Current and complete bank, credit union, investment account statements, and life insurance cash surrender value statements for the last ***three*** months.

| | | |
|---|---|---|
| **O** Checking | **O** Pension/Retirement | **O** Stock/Bonds |
| **O** Savings | **O** IRS/401K/403B | **O** Life Insurance |
| **O** CD's | **O** Annuities | |

**O** Complete Tax Return for current year

**O** Documentation of any additional income received by any member of the household

| | | |
|---|---|---|
| **O** Social Security | **O** ADC/WIC | **O** Pension/Retirement/Annuity |
| **O** Alimony/Child Support | **O** VA benefits | **O** Housing/Utility assistance |
| **O** Disability | **O** College grants/scholarships | **O** Other |

## APPLICATION FOR 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, 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.

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.

I authorize BBGH to contact me using any 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: _____**