

FINANCIAL ASSISTANCE APPLICATION

aplicación de lenguaje español disponibles a petición

Due Date: _____

This application applies to RWMC (Hospital), RW Home Health & Hospice, ABC (Anesthesia) and may apply to RWPC (Physicians Clinic). If you receive statements from other providers, please contact them to inquire about their financial assistance programs or ask if they will honor the financial assistance benefit that you received from RWMC.

Please attach the following documents; without this information, your application may be Denied

- ✓ **Paycheck stubs (last 30 days from employment, unemployment or workers' compensation)**
- ✓ **Current, *complete* bank / credit union / investment account statement for each account**
 - Checking / Debit – 30-day statement
 - Savings – 30-day statement
 - Health / Medical Savings Account
 - Pension / retirement
 - Annuities / Cert. of Deposit
 - 401(k)s / Investments
 - Stocks / Bonds
 - Keogh Accounts
 - IRAs
- ✓ **Current 1040 tax return filed with all schedules; *self-employed include a 6-month ledger of current income & expenses.***
- ✓ **Verification of any additional income received by any member of the household**
 - Social Security
 - Alimony / child support
 - ADC
 - VA benefits
 - Pension/ retirement/ annuity/ royalty payments
 - College grants and scholarships

DO NOT enclose copies of your medical/household bills

Patient / Responsible Party Information	Spouse Information
Full name	Full name
Mailing address (including city, state, zip code)	Mailing address (including city, state, zip code)
Phone #	Phone #
Social Security #	Social Security #
Date of birth	Date of birth
Marital status (<i>check one</i>) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Marital status (<i>check one</i>) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated
If widowed , what is the full name of your deceased spouse _____ Spouse's date of birth _____ Date of death _____	
Employment status (<i>check one</i>) <input type="checkbox"/> Full or part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired/Disabled	Employment status (<i>check one</i>) <input type="checkbox"/> Full or part time <input type="checkbox"/> Unemployed <input type="checkbox"/> Self-employed <input type="checkbox"/> Retired/Disabled
Employer (list company name and address)	Employer (list company name and address)
Gross income (before taxes/deductions) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	Gross income (before taxes/deductions) \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly
If unemployed , date you become unemployed _____ Date you filed for unemployment benefits _____	If unemployed , date you become unemployed _____ Date you filed for unemployment benefits _____
Do you/family currently have health insurance Yes / No If yes, name of company _____	Do you/family currently have health insurance Yes / No If yes, name of company _____
Were you given the option to apply for COBRA Ins. Yes / No	Were you given the option to apply for COBRA Ins. Yes / No

OTHER INCOME

If you receive Social Security for you or your dependents, unemployment, workers' compensation, child support, alimony, pensions, retirement income, VA benefits, rental income, college grants or scholarships, list below.

Source	Amount
Source	Amount

HOUSEHOLD MEMBERS

(List all people living in your house)

Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship
Name	DOB	Social Security #	Relationship

CHECKING/SAVINGS & DEBIT CARD ACCOUNTS

List all checking/savings and debit card accounts for household members.

Bank Name	Account Number	Type of Account
Bank Name	Account Number	Type of Account
Bank Name	Account Number	Type of Account

OTHER ACCOUNTS

List all 401(k)s, IRAs, CDs, annuities, stocks, bonds, Keogh accounts for all household members.

Bank/Company name	Account Number	Current Value
Bank/Company Name	Account Number	Current Value

VEHICLES

List all your vehicles. Include automobiles, boats, trailers and recreational vehicles.

Year / Make / Model	Value	Monthly Payment
Year / Make / Model	Value	Monthly Payment
Year / Make / Model	Value	Monthly Payment

HAVE YOU APPLIED FOR ANY ASSISTANCE LISTED BELOW?

Food stamps, utility/housing assistance? Yes / No If yes, amount receiving per month \$ _____
Medicaid / Kids Connection / ADC / Title 19 / WIC / EWM / State or Federal Grants Yes / No If YES, date applied _____ STATUS - circle one – Pending / Denied / Receiving \$ _____ Do you have Medicaid with a Share of Cost? Yes / No \$ _____ / month
Social Security Disability/SSI Yes / No If yes, name of person applying for benefits _____ Date applied _____ STATUS - circle one – Pending / Denied / Receiving \$ _____
Medical Cost-Sharing Program Do you participate in a medical cost-sharing program? Yes / No If YES, name the program _____
Legal Counsel Do you have an attorney, or legal counsel, assisting you in obtaining payment for any RWMC accounts? Yes / No If yes, date of incident _____ Type of claim _____ Name of attorney _____ Phone # _____ Address (with city & state) _____

****If you need additional space, please attach an additional sheet****

REAL ESTATE

Do you own or rent? Own Rent Monthly Mortgage \$ _____ Monthly Rent \$ _____

List all real estate you own such as ranch/farm land, rental properties and other property -- **other** than your primary residence. Provide current copy of tax assessor's valuation for property. List additional property on a separate page.

Address of property	Tax assessor value	Estimated equity	Monthly Payment
Address of property	Tax assessor value	Estimated equity	Monthly Payment

If you have an upcoming procedure at Regional West Medical Center, complete this section.

Patient Name _____ **Procedure Date** _____

Name of Procedure _____ **Physician Name** _____

PROVIDE A LETTER OF MEDICAL NECESSITY FROM YOUR PHYSICIAN FOR THIS UPCOMING PROCEDURE

Explain why you are applying for Financial Assistance from RWMC. *If you have no source of income, explain how you are paying for your living expenses (rent/utilities/food/etc.).*

I, the undersigned, certify that the above information is true and accurate. I understand that the information is subject to verification. In the review process, a credit report may be requested to verify information provided in this application. I understand that falsification of information submitted or failure to provide information may jeopardize my consideration for the program. Any financial assistance granted will remain valid for 180 days and will apply to any other accounts during this time **excluding elective procedures**. Additional information may be requested during this time period. A letter of medical necessity will be required from your physician prior to applying any reduction to accounts related to ongoing treatment.

- Accounts that are beyond 240 days old from date of first balance-due statement may not be eligible for assistance.
- Submitting this application does not exempt the applicant from monthly payment arrangements on RWMC accounts.
- Accounts that have had legal action or garnishment judgments are not eligible for financial assistance.
- Accounts that are unable to be processed by a payer due to the patient's failure to provide information are not eligible for financial assistance.
- Accounts for which patient was eligible for insurance but that information was not provided to the facility to meet the payer's timely filing guidelines are not eligible for financial assistance.
- If you participate in a healthcare sharing ministry, you are exempt from the IRS penalty fee; therefore, you may not qualify for the hospital's uninsured discount.

Signature of Applicant _____ **Date** _____

Signature of Spouse _____ **Date** _____

If you have any questions or wish to receive a written copy of the financial assistance policy, please contact us.

Phone: (308) 630-1350 or (308) 630-1462 Fax: (308) 630-1354 Email: FAST@rwhs.org

RWMC Financial Assistance (FAST) – 4021 Avenue B, Scottsbluff, Nebraska 69361-4602