

# FINANCIAL ASSISTANCE APPLICATION

aplicación de lenguaje español disponibles a petición

**Due Date:** \_\_\_\_\_

**This application applies to RWMC (Hospital), RWPC (Physicians Clinic), RW Home Health/Hospice.** 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.

### 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
Email Address:	
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
<b>If unemployed</b> , date you become unemployed _____ Date you filed for unemployment benefits _____	<b>If unemployed</b> , date you become unemployed _____ Date you filed for unemployment benefits _____
Do you/family currently have health insurance <b>Yes / No</b> If yes, name of company _____	Do you/family currently have health insurance <b>Yes / No</b> If yes, name of company _____

### 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

**INVESTMENT 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?**

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

**REAL ESTATE**

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

List additional 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.

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.).**

---

---

---

---

---

---

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

**Please attach the following documents.  
Without this information, your application may be denied.**

- 1) Paycheck stubs (last 30 days from employment, unemployment or workers' compensation)
- 2) Verification of any additional income received by any member of the household
  - Social Security
  - VA Benefits
  - Pension/Retirement
  - Alimony / Child Support
  - ADC
  - College Grants / Scholarships
- 3) 1040 Federal tax form with all schedules.  
*\*If self-employed include a 6-month ledger of current income & expenses*
- 4) Complete bank / credit union / investment account statement for each account
  - Checking / Savings / Debit Card / Health or Medical Savings Acct (30-day statement for all accts)
  - Annuities
  - 401(k)s / Investments
  - Pension / Retirement
  - Cert. of Deposits

**DO NOT enclose copies of your medical/household bills**

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.

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 at the number listed below.**

**RWMC Financial Assistance (FAST)  
4021 Ave. B  
Scottsbluff, NE 69361**

**Phone: (833) 661-1846 (Toll Free)  
FAX: (308) 630-1354  
Email: [FAST@rwhs.org](mailto:FAST@rwhs.org)**

Revised 2/10/2021