Regional West Health Services

4021 Avenue B | Scottsbluff, NE 69361 | 308-635-3711 | www.rwhs.org

FINANCIAL ASSISTANCE APPLICATION

aplicación de lenguaje español disponibles a petición

Due Date: _____

This application applies to RWMC (Medical Center) and 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 RWHS.

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 *(check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated	Marital status *(check one)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated
Email Address:	
Employment status *(check one)* ☐ Full or part time ☐ Unemployed ☐ Self-employed ☐ Retired/Disabled	Employment status *(check one)* ☐ Full or part time ☐ Unemployed ☐ Self-employed ☐ Retired/Disabled
Employer (list company name and address)	Employer (list company name and address)
Gross income (before taxes/deductions) $_____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly	Gross income (before taxes/deductions) $_____ ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Yearly
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_____	***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_____

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?

Food stamps, utility/housing assistance? Yes / No If yes, amount receiving per month $_____

Medicaid / Kids Connection / ADC / EWM 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)

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
   - Alimony / Child Support
   - VA Benefits
   - ADC
   - Pension/Retirement
   - 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 180 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.

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

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

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