Lincoln Surgical Hospital
Financial Assistance Application

1. Patient Name	Social Security #	Date of Birth	Account # **(Office Use)**
2. Guarantor's Name	Relationship to Patient	Date of Birth	Social Security #
3. Guarantor's Address	City, State, Zip	Home Telephone #	Years at Current Residence
4. Previous Address (if less than 2 years at current)	City, State, Zip	Marital Status	Spouse's Name & Social Security #
5. List Names and Ages of All Dependents Living in Household			

6. Employer (Patient or Guarantor)	Previous Employer (If less than 2 years at current employer)	Spouse's Employer
Address		
Business Telephone #		
Job Title		
Length of Employment		
Hourly Rate & # of Hours per Week		
Monthly Gross Income		
Monthly Take-Home Pay		

7. Other Income Source and Amount (include tips)	Total Monthly Family Gross Income

8. Have you applied for Medicaid or other State/County Assistance? **Yes** **No**	
Application Date	Caseworker Name and Telephone Number

9. Have you ever filed Bankruptcy?	Chapter 7	Chapter 13	Date Filed	Date of Discharge

Note: Attach additional sheet if necessary

Bank Information

***If there are multiple checking/savings accounts please provide detail and the total balance for all accounts**

10. **Account Description (Bank Name & Account #)**	**Account Balance**
Checking	
Savings	
Other Bank Accounts	

11. Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

12. **Vehicle Make/Model/Year**	**Monthly Payment**	**Remaining Balance Due**

13. **Expense**	**Monthly Payment**	**Payment To**	**Account #**	**Balance Due**
Rent/Mortgage				
Bank Loan(s)				
School Loan(s)				
Medical Bills				

14. **Credit Card**	**Monthly Payment**	**Payment To**	**Account #**	**Balance Due**	**Credit Limit**

15. **Other Expenses**	**Monthly Payment**
Groceries	
Utilities	
Telephone	
Gas (Car)	
Medication	
Life Insurance	
Auto Insurance	
Cable Television	
Child Care	
Child Support/Alimony	
Other	

16. **Total Monthly Expenses:**

The following income verification must be attached:

- **Last year's Form W-2**
- **Pay stubs (last 90 days)**
- **Last year's tax return (Form 1040)**
- **Social Security, unemployment compensation forms, etc.**

*****PLEASE READ*****

DOCUMENTATION: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements and copies of social security checks (or letters). If there is no income please explain how expenses are being met. It is important to explain a lack of income completely so full consideration of your application can be made. If the patient/guarantor or spouse is self-employed, attach the last 3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete it will be returned to you. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:

1. Stating that the patient/guarantor has completed this form accurately.
2. Stating that the patient/guarantor will apply for any assistance necessary to pay this bill. If the patient/guarantor has sufficient debt capacity, the patient/guarantor may be expected to acquire a bank loan or pay for their services with a credit card.
3. Authorizing Lincoln Surgical Hospital to obtain credit information and perform a credit check.

CERTIFICATION

1. **I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.**
2. **I will apply for any and all assistance that may be available to help pay this bill.**
3. **I understand the information submitted is subject to verification; therefore, I grant permission and authorize any employer, bank, insurance company, real estate company, financial institution and credit grantors of any kind to disclose to any authorized agent of Lincoln Surgical Hospital information as to my past and present employment, accounts, policies, experiences and all pertinent information related thereto. I authorize Lincoln Surgical Hospital to perform a credit check for both guarantor/patient and spouse.**

Signature (Guarantor/Patient)	**Date**
Signature (Spouse)	**Date**

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Lincoln Surgical Hospital
1710 South 70th Street, Suite 200 Lincoln, NE 68506 402-484-9090

DIRECTIONS FOR COMPLETING THE FINANCIAL ASSISTANCE APPLICATION

1. Complete the patient name, social security number and date of birth.

2. Complete the guarantor name, relationship to patient, date of birth and social security number. If the guarantor is the same as the patient, please write "same" in these fields.

3. Complete the guarantor's address, home telephone number and length of residence at this address.

4. Complete the guarantor's previous address (if current residence is less than two years), marital status, spouse's name and social security number. If you do not have a spouse, please write "N/A" in this field.

5. List the names and ages of all dependents currently living in the household.

6. Complete the employer information for the patient or guarantor, depending on who has responsibility for the balance due. This includes the employer's name, address, the patient/guarantor's job title and the business telephone number. Provide the length of employment, hourly or salary rate, number of hours worked per week and the monthly income (both gross and take-home). If there is no employer please note how expenses are being met.

   Complete the previous employer information for the patient/guarantor if the person has been at their current job for less than two years. This includes the employers' name, address, person's job title, business telephone number, length of employment, hourly or salary rate and the monthly income (both gross and take-home). If patient/guarantor has been with their current employer for more than two years, write "N/A" in these fields.

   Complete the employer information for the patient/guarantor's spouse. Include the employer's name, address, business telephone number, spouse's job title, length of employment, hourly (or salary) rate, and monthly income (both gross and take-home). If the spouse is unemployed or there is no spouse, write "N/A" in this field.

7. Complete the other income source and amount field. This is for child support, alimony, social security, bonus amounts from employers, tips, rental income, pension income, welfare and VA benefits. Complete the total monthly family gross income. If there has been no income, explain how expenses are being met.

8. Answer the questions regarding Medicaid and other State/County assistance. Indicate if you have applied for assistance and on what date. Provide the assigned Case Worker's name and telephone number. You may attach a separate sheet of paper if necessary. **Please provide a copy of the denial letter if applicable.** Write "N/A" if this field does not apply to you.

9. Indicate if you have ever filed bankruptcy. Attach a separate sheet of paper if necessary for any explanation.

10. Complete the banking information as requested. Write "N/A" in the account fields that do not pertain to you.

11. Complete the section listing other assets you have. This includes stocks, bonds, property, boats and businesses you own. Attach a separate sheet of paper if necessary to provide complete details. If there are no additional assets, please write "N/A".

12. Complete the vehicle information as requested. Write "N/A" in the fields that do not pertain to you.

13. **RENT/MORTGAGE:** Write the amount you pay in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others.

    BANK LOANS: Indicate any bank loans you are currently paying. Write the monthly payment amount, to whom the payment is made, account number and current balance due. If you do not have any bank loans, write "N/A".

    SCHOOL LOANS: List any educational loans you are currently paying. This may include college loans, private school loans (or tuition), or any other loans that pertain to education. Please specify the type of loan. If this field does not pertain to you, write "N/A".

    MEDICAL BILLS: Add up any medical bills you are paying on a monthly basis and write the total amount in this field. Use a separate sheet of paper to list these amounts. If there are no monthly medical payments being made, please write "N/A".

14. **CREDIT CARDS:** Indicate any credit card bills you are currently paying. Indicate the monthly payment amount, to whom the payment is made, the account number and the current balance due and the credit limit for each card. Use an additional sheet of paper if necessary to complete this information. If you do not pay any monthly credit card bills, please write "N/A" in this field.

15. **GROCERIES:** Write in the amount you pay for groceries on a monthly basis.

    UTILITIES: Write the total amount you pay on a monthly basis for household utilities (electricity, gas, water, trash, etc.) If you do not pay any monthly utilities write "N/A" and explain.

    GAS (CAR): Write the amount paid on a monthly basis for vehicle fuel. Write "N/A" if this field does not pertain to you.

    MEDICATION: Write the total amount paid on a monthly basis for prescription medication. Write "N/A" if this field does not pertain to you.

    LIFE INSURANCE: If you have a life insurance policy, please write the monthly payment amount. Write "N/A" if you do not pay for life insurance.

    AUTO INSURANCE: Write the monthly payment amount for auto insurance. If there are multiple vehicles, write the total amount paid for all. If you pay on a quarterly basis, divide the quarterly payment by three and write that amount. If you pay every six months, divide the amount by six and write that amount. Write "N/A" if you do not pay auto insurance.

    CABLE TELEVISION/SATELLITE: Write the amount you pay for cable or satellite television each month. Write "N/A" if this field does not pertain to you.

    CHILD CARE: Write the amount you pay on a monthly basis for child care. Write "N/A" if this field does not pertain to you.

    CHILD SUPPORT/ALIMONY: Write the amount you pay on a monthly basis for child support and/or alimony. Write "N/A" if this field does not pertain to you.

    OTHER: Write any other monthly payments you make. Write "N/A" if this field does not pertain to you.

16. **TOTAL MONTHLY PAYMENTS:** Add all of the above payment amounts and write the total in this field.