Providence Medical Center Financial Assistance Application

Date of Application: _____

Name: _____ **DOB**: _____ **SSN:** _____

Address: _____ **Phone:** _____

This form must be filled out in full, sign, and date at the bottom. If you qualify, you may be eligible for a full or partial discount of your balance due.

1. Have you had health insurance coverage within the last 3 months? . . . . . ☐ Y ☐ N
2. Have you applied for Medicaid or Disability? . . . . . ☐ Y ☐ N
3. How many people live in your household? _____ Their ages? _____
4. Household income before taxes are taken out? $_____

   If you had no income, please provide how your bills were paid. _____

   _____
5. Will your household income be a lot different this year? . . . . . ☐ Y ☐ N

   If yes, why and how much? _____

Proof of Income: COPIES OF ONE (1) OF THE FOLLOWING ITEMS MUST BE SENT WITH THIS APPLICATION:

- ☐ Federal Tax Return (most recent) **(preferred option)**
- ☐ Last Two Pay Stubs for yourself and spouse
- ☐ Last Two Bank Statements

RETURN TO:
Providence Medical Center
1200 Providence Rd
Wayne, NE 68787

MARK OTHER INCOME SOURCES:

☐ Social Security ☐ Workman's Comp ☐ Unemployment ☐ VA Assistance ☐ Disability ☐ Child Support
☐ Alimony or other income _____

Tell us why you need help paying your bill. _____

_____

I have filled out this form with correct information. I understand that if I have been untruthful, I will not qualify to get help paying my bill.
I agree to provide more information if asked.

Signed: _____ **Date:** _____

- If you qualify for help, this decision will remain in effect for 6 months from the date of the qualification letter.
- All required information must be returned along with a completed application for a review to take place.
- Please feel free to contact us with any questions regarding your specific situation at **(402) 375-7670**.

PMC
Providence Medical Center