Franciscan Healthcare
Your health is our passion.

430 N. Monitor Street | West Point, NE 68788 | P: 402.372.2404 | F: 402.372.2360

FINANCIAL ASSISTANCE APPLICATION

This information is confidential and will be used only to make a determination for payment purposes. Please complete this application and return form to: _____.
If you have questions, please contact _____402-372-4029.

Please attach a copy of the most current tax filing forms (1040 or 1040A)

Patient/Guarantor: _____
Name Social Security # (optional) Date of Birth

Spouse : _____
Name Social Security # (optional) Date of Birth

Address: _____
Street City, State Zip Phone Number

Guarantor Employer: _____
Name Address Occupation Phone Number

Spouse Employer: _____
Name Address Occupation Phone Number

Number of persons in the household (Include yourself) _____adults _____children

Have you ever filed for bankruptcy? _____yes _____no If yes, date: _____

Financial Information: (Monthly Income for Household)

ATTACH COPY OF PAY STUBS

INCOME

Sources of Income	Guarantor	Spouse
Gross Monthly Wages		
Self Employment Income		
Public Assistance		
Social Security		
Unemployment		
Worker's Compensation		
Alimony		
Child Support		
Military Allotments		
Pensions/Retirement		
Rental Income		
Other Sources		
Total Income:		

EXPENSES

Monthly Expenses	Total Monthly Expenses
Rent	$
Alimony	$
Child Support	$
Groceries/food	$
Electricity	$
Gas	$
Water/Sewer/Garbage	$
Telephone/Cell Phone	$
Cable	$
Clothing	$
Auto Insurance	$
Health Insurance	$
Medical (not paid by insurance)	$
Homeowner's or Renter's Insurance	$
Day Care	$
Retirement	$
Others:	$
Line A Total	$

Have you applied for a commercial loan?_____yes _____ no _____approved _____denied, if so date _____ Lending institution name: _____

Have you applied for: _____Medicaid _____ Social Security/Disability?
Approved Date: _____ Denied date: _____

If you expect a change in income, health, or other circumstances, or cannot provide the requested information, then please explain. Attach additional pages as necessary.

I (we) certify that the information provided is true and accurate to the best of my (our) knowledge. I (we) hereby authorize the hospital and/or its agents to verify the information provided in this application. I (we) hereby authorize that verification can include, but not limited to, the inquiry of my (our) credit history through a credit reporting agency. If any of the information given proves to be untrue, then I (we) understand that the hospital may re-evaluate my (our) financial status and take whatever action it deems appropriate.

_____	_____	_____
Print Name	Print Name	Date
_____	_____	_____
Signature	Signature	Date

Please attach a copy of the most current tax filing forms (1040 or 1040A)

This form must be completely filled out. If you fail to provide Franciscan Healthcare representatives with the required information your application will not be reviewed.