Franciscan Care Services, Inc.

"Your Choice for Local Healthcare and Elderly Services"

430 N Monitor, West Point, NE 68788 402/372-2404 phone 402/372-2360 fax

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 # Date of Birth

Spouse : _____
Name Social Security # Date of Birth

Address: _____
Street City, State Zip Phone Number

Guarantor Employer: _____
Name Address Occupation Phone Number

Spouse Employer: _____
Name Address Occupation Phone Number

Marital Status: (check one) ____Married _____Single _____Divorced _____Widow (er)

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	$

FINANCIAL INFORMATION – LIABILITIES & OBLIGATIONS OWED TO OTHERS:

Company/Person Money Owed to (Please list name):	Account Number	Amount Owed	Current Value/Credit Available	Monthly Payment
Mortgage on Home at_____				
Auto #1 loan at _____ *Year*_____ *Make*_____ *Model*_____				
Auto #2 loan at _____ *Year*_____ *Make*_____ *Model*_____				
Credit Card: Name:_____				
Credit Card: Name:_____				
Total Payments:				

Total Monthly Cash Outlays (Line A + Line B) _____

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: _____

FINANCIAL RESOURCES – ASSETS (Please attach copies of current statements for ALL accounts listed below.

Cash	Bank or other Financial Institution	Account Number	Current Balance
Checking Account #1			**$**
Checking Account #2			**$**
Savings Account			**$**
CD			**$**
Credit union			**$**
IRA-other			**$**
			$
			$
			$

Total Cash (C) $_____

OTHER ASSETS:	**Circle**		**Value**
Boat	Yes	No	$_____
Camper/Trailer	Yes	No	$_____
Jet Ski	Yes	No	$_____
Snowmobile	Yes	No	$_____
ATV	Yes	No	$_____
Motorcycle	Yes	No	$_____
Land	Yes	No	$_____
Property	Yes	No	$_____
Other assets (list) _____	Yes	No	$_____
		Total (D)	$_____

If you expect a change in income, health, or other circumstances, or can not 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 Care Services representatives with the required information your application will not be reviewed.