



INSTRUCTIONS FOR COMPLETING APPLICATION FOR UNCOMPENSATED CARE

- A. Fill out the application completely. The application will be considered incomplete until all requested information is received. Please note that we must have verification of income from all sources listed on the application and for all family members shown as dependents.
- B. Verification of income consists of the following:
- 1) Employed Person: The verification shall consist of a copy of last year's tax return, copies of payroll check stubs and/or certified statement of income from your employer(s) for the past 3 months. (The past 12 months may be helpful.) A personal financial statement is attached and must also be completed for all family members shown as dependents.
 - 2) Farmers and Self-Employed Persons: Verification shall consist of a copy of last year's tax return. (Prior years' losses are not applicable toward qualification.) Any and all depreciation expense incurred in calculating total income shall be disregarded. A personal financial statement is attached and must also be completed for all family members shown as dependents.
 - 3) Unemployed and Disabled Persons: The verification shall consist of proof of income from past employment if unemployed less than 12 months; proof of income from unemployment compensation; disabled persons, proof of income from Social Security or any other type of disability income; and proof of income from past employment if disabled less than 12 months. A personal financial statement is attached and must also be completed for all family members shown as dependents.
 - 4) College Students: The verification shall consist of proof of income from student grants or stipends and proof of income from any employment, husband or wife, while a student, including summer employment. A personal financial statement is attached and must also be completed for all family members shown as dependents.

If you have questions concerning the above instructions, please contact the Patient Financial Counselor at 402-887-6286. If the information received is incomplete, the hospital will provide the patient with written notice.

PLEASE RETURN WITHIN 10 DAYS



**REQUEST FOR DETERMINATION OF ELIGIBILITY FOR
UNCOMPENSATED SERVICES**

PATIENT NAME: _____ DATE OF SERVICE: _____

I hereby request that Antelope Memorial Hospital make a written determination of my eligibility for Uncompensated Care at Antelope Memorial Hospital. I understand that the information I submit concerning my annual income and family size is subject to written verification by Antelope Memorial Hospital. I hereby authorize and instruct any person, agency, my employer, or any consumer or credit reporting agency to furnish Antelope Memorial Hospital with any information in response to their financial inquiries. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of uncompensated services and that I will be liable for all services provided.

Date: _____ Person Making Request: _____

1. Name: _____ Spouse Name: _____

2. Address: _____ Address: _____

3. City: _____ City: _____

4. State: _____ Zip: _____ State: _____ Zip: _____

5. Occupation: _____ Occupation: _____

6. Employer: _____ Employer: _____

7. Address: _____ Address: _____

8. Family Size:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Name</u>	<u>Age</u>	<u>Relationship</u>
_____			_____		
_____			_____		
_____			_____		
_____			_____		

9. Type Of Health Insurance: _____

10. PERSONAL FINANCIAL STATEMENT

Date of valuation _____

* Attach separate sheet if you need more space to complete detail schedule

Assets (assets you own)	Amount
Cash in this bank: Checking	
Savings	
C.D.'s	
IRA	
Cash in other banks	
Due from friends, relatives and others (schedule 1)	\$ -
Mortgage and contracts for deed owned (schedule 2)	\$ -
Securities owned (schedule 3)	\$ -
Cash surrender value of life insurance (schedule 4)	\$ -
Homestead (schedule 5)	\$ -
Other real estate owned (schedule 5)	\$ -
Automobiles (year, make, model)	
Personal Property	
Other assets (detail)	
TOTAL	\$ -

Liabilities (debts you owe)	Amount
Loans payable to banks (schedule 7)	\$ -
Loans payable to others (schedule 7)	
Installment contracts payable (schedule 7)	
Amounts due to dept. stores and others	
Credit cards (MasterCard, Visa & others)	
Income taxes payable	
Other taxes payable	
Loans on life insurance (schedule 4)	\$ -
Mortgage on homestead (schedule 6)	\$ -
Mortgage or liens on other real estate (schedule 6)	\$ -
Other liabilities (detail)	
TOTAL LIABILITIES	\$ -
Net worth (total assets less total liabilities)	\$ -
TOTAL	\$ -

Annual Income	Applicant	Joint Applicant
Salary		
Commissions		
Dividends		
Interest		
Rentals		
Alimony, child support or separate maintenance income received under ___ Court Order ___ Written Agreement ___ Oral Understanding (You need not reveal this income if you do not wish to have it considered as a basis for repaying this obligation)		
Other		
TOTAL INCOME	\$ -	\$ -

Contingent liabilities	Amount
As endorser	
As guarantor	
Lawsuits	
For taxes	
Other (detail)	
o Check here if "none"	
TOTAL CONTINGENT LIABILITIES	\$ -

SCHEDULE 1 DUE FROM FRIENDS, RELATIVES and OTHERS

Name of debtor	Owed to	Collateral	How payable	Maturity Date	Unpaid balance
			per		
			per		
			per		
TOTAL					\$ -

SCHEDULE 2 MORTGAGE AND CONTRACTS FOR DEED OWNED

Name of debtor	Type of property	1st or 2nd lien	Owed to	How payable	Unpaid balance
				per	
				per	
TOTAL					\$ -

SCHEDULE 3 SECURITIES OWNED

No. shares or Bond amount	Description	In whose name(s) registered	Cost	Present Market Value	L- listed U- unlisted
TOTAL			\$ -	\$ -	

SCHEDULE 4 LIFE INSURANCE

Insured	Insurance Company	Beneficiary	Face value of policy	Cash value	Loans
TOTAL				\$ -	\$ -

SCHEDULE 5 REAL ESTATE

Address and Type of Property	Title in name(s) of	Monthly Income	Cost / Year Acquired	Present Market Value	Amount of Insurance
Homestead			\$ - Year		
			\$ - Year		
			\$ - Year		
			\$ - Year		
			\$ - Year		

SCHEDULE 6 MORTGAGES OR LIENS ON REAL ESTATE

To Whom Payable	How Payable	Interest Rate	Maturity Date	Unpaid Balance
Homestead	\$ - per			
	\$ - per			
	\$ - per			
	\$ - per			
	\$ - per			

SCHEDULE 7 LOANS PAYABLE TO BANKS & OTHERS AND INSTALLMENT CONTRACTS PAYABLE

To Whom Payable	Address	Collateral or Unsecured	How Payable	Maturity Date	Unpaid Balance
			\$ - per		
			\$ - per		
			\$ - per		
			\$ - per		

I affirm that the above preceding information is true and correct to the best of my knowledge. Further, the undersigned hereby authorize Antelope Memorial Hospital/AMH Family Practice to contact any credit reporting agency or any other credit references for the purpose of obtaining a consumer credit report for evaluation creditworthiness in connection with this application.

Date: _____ Signature: _____

Date Received: _____ Signature: _____