



Cozad Community Hospital
300 East 12th Street P.O. Box 108
Cozad , NE 69130
(308) 784-2261
(308) 784-4691 FAX

APPLICATION FOR FINANCIAL ASSISTANCE

OTHER INFORMATION:

VERIFICATION: Your eligibility may be checked by hospital officials at the time of submitting the application. You will be asked to provide specific information to prove that you qualify for reduced or free care. A copy of your most recent filed tax return and bank account statements will be required.

Patient Name (print)

Date(s) of Service

FAIR HEARING: If you do not agree with the Hospital's decision on your application or the result of verification, you may wish to discuss it with the Hospital Administrator. You also have the right to a fair hearing with the Governing Board of the Cozad Hospital District #2. You can do this by calling or writing to the following:

Cozad Hospital Board
300 E 12th Street, P.O Box 108
(308) 784-2261

CONFIDENTIALITY: The information you give on the application will be used only to allow you or for whom the service was provided and for whom the application was prepared to get free or sliding scale fees and to verify eligibility.

In the operation of this policy, no patient will be discriminated against because of race, sex, color, national origin, age, handicap, or ability to pay.

You will be notified when your application is approved or disapproved.



To Whom it May Concern:

Please mark the statement that pertains to your situation and provide an explanation for each unanswered statement.

_____ I have enclosed a copy of my income taxes from the past two years

_____ I have not filed an income tax return the past two years because my earnings were less than required to file a tax return.

_____ My only source of income for the past two years has been Social Security.

_____ I have not had any source of income the past two years.

_____ I have filled out the Personal Financial Statement and am returning it to you in the enclosed envelope.

_____ I am providing a copy of my most current bank statement (30 days).

_____ I am unable to provide a current bank statement.

Printed Name

Signed Name

Signed before me this _____ day of _____, _____
Date Month Year

Notary Signature

**PERSONAL FINANCIAL
STATEMENT**



P.O. BOX 108
300 East 12th
Cozad, NE 69130
(308) 784-2261

Responsible Party			
Name _____		Age _____ School Yrs. _____	
SSN _____		Phone _____	
Present Address -	No. Years _____	Own []	Rent []
Street _____			
City/State/Zip _____			
Former address if less than 2 years at present address -			
Street _____			
City/State/Zip _____			
Years at former address _____		Own []	Rent []
Marital	Married []	Separated []	Number of people in household _____
Status	Unmarried (Inc. single, divorced, widow) []		
Dependents -		Number _____	Ages _____
Name and Address of Employer		Years employed in this line of work or profession? _____	
_____		Years _____	
_____		Years on this job _____	
_____		Self Employed []	
Position/Title _____		Type of Business _____	
Spouse			
Name _____		Age _____ School Yrs. _____	
SSN _____		Phone _____	
Present Address -	No. Years _____	Own []	Rent []
Street _____			
City/State/Zip _____			
Former address if less than 2 years at present address -			
Street _____			
City/State/Zip _____			
Years at former address _____		Own []	Rent []
Marital	Married []	Separated []	Number of people in household _____
Status	Unmarried (Inc. single, divorced, widow) []		
Dependents -		Number _____	Ages _____
Name and Address of Employer		Years employed in this line of work or profession? _____	
_____		Years _____	
_____		Years on this job _____	
_____		Self Employed []	
Position/Title _____		Type of Business _____	

**MONTHLY INCOME**

Responsible Party \$ _____

Spouse \$ _____

Total \$ _____

MONTHLY EXPENSES

Total \$ _____

MEDICAL BILLS

Total amount of all medical bills \$ _____

PLEASE INCLUDE A COPY OF ALL
YOUR CURRENT MEDICAL BILLS**THESE QUESTIONS APPLY TO BOTH RESPONSIBLE PARTY AND SPOUSE**If "yes" answer is given to a question in this
column, please explain in attached sheetResp. Part Spouse
Yes or No Yes or No

Are there any outstanding judgements against you? _____

Have you been declared bankrupt within the past 7 years? _____

Are you obligated to pay alimony, child support, or separate maintenacne? _____

Resp. Part Spouse
Yes or No Yes or No

Are you a co-maker or endorser on a note? _____

Are you a U.S. citizen? _____

Are you a party to a law suit? _____

** Copies of signed Federal Income Tax Returns for last two years required.

** All present monthly expenses of responsible party and spouse should be listed on a combined basis.

List Previous Credit References for Responsible Party

Creditor's Name and Address	Account #	Purpose	Highest Balance	Date Paid

Additional names under which credit has previously been received: _____

I HEREBY ACKNOWLEDGE THAT THE ABOVE INFORMATION, GIVEN TO COZAD COMMUNITY HOSPITAL IS TRUE AND CORRECT; AND I HEREBY AUTHORIZE COZAD COMMUNITY HOSPITAL OR THEIR AGENT TO VERIFY ANY INFORMATION GIVEN ON THIS FORM.

RESPONSIBLE PARTY SIGNATURE_____
SPOUSE SIGNATURE_____
DATE