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 explaination 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 __________, 2022

____
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 Staus	Married ( ) Separated ( ) Unmarried (Inc. single, divorced, widow) ( )

Number of people in household ________

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 Staus	Married ( ) Separated ( ) Unmarried (Inc. single, divorced, widow) ( )

Number of people in household ________

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 sheet

	Resp. Part Yes or No	Spouse Yes or No
Are there any outstanding judements 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 Yes or No	Spouse 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 HOSPITA 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**