Great Plains Health

FINANCIAL ASSISTANCE APPLICATION

PO BOX 1167
NORTH PLATTE, NE 69103
308-568-7112

This application applies to GPH Hospital, GPH Home Care, GPH DME, GPH Physicians and services under the GPH umbrella only. This program does not cover outside medications, elective or cosmetic procedures. If you receive statements from other providers, please contact them to inquire about payment arrangements.

****Attach the following information; applications submitted without documentation will be denied.****

Most Current Complete Tax return with all schedules-if self-employed, include your quarterly tax payment documents.

Paycheck stubs for last 60 days of employment: this includes unemployment, worker's compensation and short term disability if you are receiving.

Verification of any additional income received by any member of the household:

* Social Security
* SNAP Benefits
* VA Benefits
* Pension / retirement / annuity
* 1099's
* other documentation as may be requested

DO NOT ENCLOSE COPIES OF YOUR MEDICAL/HOUSEHOLD BILLS

Patient/Responsible Party Information	**Spouse Information**
Full name	Full name
Mailing address	Mailing address
Phone #	Phone #
Social Security #	Social Security #
Date of Birth	Date of Birth
Employment Status	Employment Status
Employer name	Employer name

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Patient/Responsible Party Information	Spouse Information
Gross Income Monthly	Gross Income Monthly
Gross Income Annually	Gross Income Annually

If unemployed, date you became unemployed	If unemployed, date you became unemployed

If you have become unemployed in the last 6 months, please provide documentation from your employer regarding your last date of employment and if you are receiving unemployment benefits or paid leave.

If you have no source of income, please include a letter explaining how you are paying for your living expenses. If you are receiving assistance from friends and/or family, please include a letter from them as well.

Dependents

Name	**Age**	Relationship

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- I declare under penalty of perjury that the answers I have given are true and complete to the best of my knowledge.
- Submitting this application does not exempt the applicant from monthly payment arrangements on Great Plains Health accounts.
- Accounts that are beyond 240 days old from date of first balance due statement are not eligible for assistance.
- Accounts for which the patient was eligible for insurance but that information was not provided to the facility to meet the payer's timely filing guidelines are not eligible for assistance.
- I agree that in consideration for receiving healthcare services as a result of an accident or injury, to reimburse the hospital from proceeds of any litigation or settlement resulting from such act.
- I understand that Great Plains Health is required by law to keep any information I provide confidential.
- I understand that if I do not qualify for financial assistance, I will be personally liable for the charges of the services rendered by Great Plains Health.

Signature of Applicant _____ **Date** _____