Date Given _____ By _____ Date Returned _____

Application for Charitable Care

Name:_____Social Security # or last 4 digits (optional) _____ Date of Birth _____

Spouse Name:_____Social Security # or last 4 digits (optional)_____ Date of Birth _____

Address:_____ Phone #_____

City, State, Zip: _____ Cell Phone #_____

Dependents Name: _____ DOB:_____Dependents Name: _____ DOB:_____

Dependents Name: _____ DOB:_____Dependents Name: _____ DOB:_____

Income Verification:

Please attach copies of w-2s, current tax return or paystubs for at least 3 months to this application for all working members in your household. **Failure to do so will result in denial of application.**

SELF	SPOUSE
Employer: _____	Employer: _____
Address:_____	Address:_____
Phone #_____	Phone #_____
Monthly Gross Income: _____	Monthly Gross Income: _____
Other Monthly Income:_____	Other Monthly Income: _____
Other Monthly Income: _____	Other Monthly Income: _____

(Welfare, SSI, Child Support, Workman's Comp., Unemployment, Pensions, Rents, Alimony, Veteran's Survivor Benefits, Retirement)

Do you have a Health Savings Account (HSA) and/or Flexible Spending Account _____Yes _____No

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by Lexington Regional Health Center. I hereby grand permission to Lexington Regional Health Center to investigate the information contained therein.

Signature _____ Signature_____Date: _____

Please print, completed form and mail or deliver to
Lexington Regional Health Center
c/o Business Office
PO Box 980
Lexington, Ne 68850
(308) 324-5651

LEXINGTON REGIONAL HEALTH CENTER

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Financial Statement

Monthly Income of Household: Written proof is required.

Item	Self	Spouse	Dependents	Total
Gross Earnings				
Worker's Comp				
Interest/Dividends				
Alimony				
Rental				
Military				
Food Stamps/WIC				
ADC				
Unemployment				
Disability/SSI				
Social Security				
Other Income				
Any Possible Settlements in the Future				
			TOTALS	

We need a copy of the following in order for a determination for assistance to be made. (If Applicable)

_____ A "Letter of Rejection" from the Department of Social Services (Medicaid), go to www.accessnebraska.gov enter English/Spanish, answer the questions, and hit apply. Then print if denied. Or in-house social services determine patient not eligible.

_____ Copy of previous year's income tax return with W-2's. Must be a FULL copy & signed.

_____ Copy of most recent paycheck stub.

_____ Copy of last three months of bank statements with an explanation of all deposits.

_____ Copy of any compensation received, i.e., unemployment.

_____ Copy of "Social Security Determination," if applicable.

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Office Use Only	**Amount Approved**		
Total Income _____ Total Assets _____ Size of Household _____ Guidelines $_____	Approved By _____ Date _____ Denied By _____ Date _____	Approved By _____ Date _____ Denied By _____ Date _____	Approved By _____ Date _____ Denied By _____ Date _____