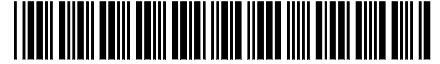
Grand Island
REGIONAL MEDICAL CENTER

Patient Name: Mouse, Mickey Mortimer
Med Rec Number: M1234567 Acct Number: V000123456
Age: 21 Gender: Male DOB: 12/03/1983 Svc Date: 9/5/2017



DUE BY:

PATIENT FINANCIAL ASSISTANCE APPLICATION

❏ Pre-Determination

#1 Responsible Party

Last name | First name | Middle name

Address | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

❏ Single ❏ Married ❏ Separated ❏ Divorced ❏ Widow/Widower

#2 Spouse and/or Additional Household Members

Last name | First name | Middle name

Address (if different from Patients) | City | State | Zip Code

Social Security | Date of Birth | Age

Home phone | Cell phone

Employer Name | Years employed | Work phone

#3 Dependents

Number of legal dependents ____________ Ages of legal dependents ____________

#4 Insurance Information

Does anyone in the household have health insurance? ❏ Yes ❏ No

Insured Name | Health Ins. Name | Policy number

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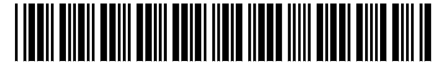


#5 Household Monthly Gross Income

	Responsible Party	Additional Household members
Employment **(<u>Gross Earnings</u>)**	$	$
Self Employment *Business Type ________________	$	$
Social Security	$	$
Real Estate Rental Income	$	$
Unemployment- Date Ended __________	$	$
Disability	$	$
Workmen's Compensation	$	$
Child Support	$	$
Alimony	$	$
Military Income	$	$
Food Stamps	$	$
Other	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed

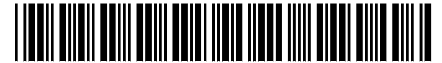
#6 Savings and Investments

❏ I do not have a checking account

❏ I do not have a savings account

	Responsible Party	Additional Household members
Checking Account Balance	$	$
Savings Account Balance	$	$
Retirement	$	$
CD/IRA/403b/401k/Annuities/IRA's	$	$
Stocks/Bonds/Interest/Life Ins./Land	$	$
Other Savings and Investments * __________________________	$	$
TOTAL	$	$

Use additional paper to include any other household members savings or investments not listed



#7 Other Assets

	Year	Make	Model	Balance Remaining	Value
Auto				$	$
Auto				$	$
Boat				$	$
Camper/RV				$	$
Motorcycle				$	$
ATV				$	$
				$ TOTAL	$ TOTAL

#8 Monthly Expenses (please round to nearest dollar)

Housing

- ❏ Rent payment $ ____
- ❏ Mortgage payment $ ____

*Value of Home $ ____

Second mortgage payment $ ____

*Remaining balance $ ____

Lot rent (mobile homes) $ ____

Renters insurance $ ____

Homeowners insurance (If not included in mortgage) $ ____

Property tax (If not included in mortgage) $ ____

Transportation/Vehicles

Automobile payment $ ____

*Remaining balance $ ____

Year ____ Make ____ Model ____

Automobile payment $ ____

*Remaining balance $ ____

Year ____ Make ____ Model ____

Automobile payment $ ____

*Remaining balance $ ____

Year ____ Make ____ Model ____

Insurance $ ____

Gas $ ____

Housing Utilities

Electric $ ____

Water $ ____

Gas $ ____

Garbage removal $ ____

Telephone (land line) $ ____

Telephone (cellular) $ ____

Cable and Internet $ ____

Medical

Health insurance $ ____

Life insurance $ ____

Dental insurance $ ____

Medications $ ____

Other- ____ $ ____

*Balance $ ____

Other- ____ $ ____

*Balance $ ____

Other- ____ $ ____

*Balance $ ____

Other- ____ $ ____

*Balance $ ____

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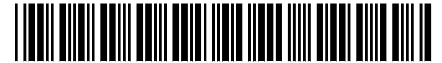

#8 Monthly Expenses (continued)

Credit Cards

Name	
Payment	$
Balance	$
Name	
Payment	$
Balance	$
Name	
Payment	$
Balance	$
Name	
Payment	$
Balance	$
Name	
Payment	$
Balance	$

Other Loans

Type	
Payment	$
Balance	$
Type	
Payment	$
Balance	$
Type	
Payment	$
Balance	$
Type	
Payment	$
Balance	$

Miscellaneous

Food and Paper Products	$	Child Care	$
Clothing/Shoes	$	Child Support	$
Entertainment	$	Alimony Paid	$
Charity Contributions	$	Lawn Care	$
Newspaper	$	Snow Removal	$

TOTAL EXPENSE (For Office Use Only) $ X 12 = $

#9 Other Comments

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#10 Assignment of Rights

I understand that proof of income (see Financial Assistance Checklist) is required to process my application. I also understand that more information may be requested before my eligibility can be determined.

I hereby acknowledge that the information listed on this application is true and correct. If any information given proves to be untrue or is withheld I understand the hospital may take whatever action is appropriate. This action may include denial of this application up to and including denial of all future applications.

I agree that I will repay the assistance I was rewarded if I receive payment of any kind for the medical services covered by this application. Examples of this would be: insurance payments, payments from government programs, lawsuit settlements, or any other source of payment received.

Click here to sign	Click here to sign
Signature	Signature

Grand Island Regional Medical Center will not grant financial assistance on procedures that are not deemed medically necessary such as; fertility testing, fertility treatment, cosmetic procedures, etc.

You must be a US Citizen, US National, or alien lawfully present in the United States in order to qualify for any type of financial assistance offered by Grand Island Regional Medical Center.

Failure to complete and/or cooperate with all other GIRMC and governmental assistance programs; such as MASH, Medicaid, and/or the Healthcare Reform which began 1/1/14, disqualifies you from the financial assistance program offered by Grand Island Regional Medical Center.

In the future if your financial situation improves and you would like to remember the assistance you received please consider making a donation to Grand Island Regional Medical Center.