Dear Valued Patient,

Thank you for choosing **Grand Island Regional Medical Center** for your healthcare needs. We are committed to providing quality care to our community, and we understand that medical expenses can be a burden. That's why we're pleased to offer a **Patient Financial Assistance Program** to help those who qualify with their healthcare costs at our facility.

To apply for financial assistance, please submit a **completed application** along with the following **required documentation** for verification:

Documents Needed:

- **A completed Financial Assistance Application**
- A copy of your **most recent tax return**
- **One month's worth of paystubs** (or proof of income – unemployment, disability check, social security award letter)
- Your **most recent bank statement**, including all transactions history
- **A letter of explanation** for any documentation you are unable to provide

You may submit your completed application and documents by:

Mail:

Grand Island Regional Medical Center

Patient Financial Services

3533 Prairieview Street

Grand Island, NE 68803

Email: PFS@bryanhealth.org

If you have any questions or need assistance, please contact us at 402-481-5791 or 877-577-9277

Sincerely,

Grand Island Regional Medical Center

Patient Financial Services Team

Bryan Health

Financial Assistance Application Form

Patient Name(s): _____ **Guarantor Number(s):** _____

GUARANTOR	SPOUSE
Name Date of Birth	Name Date of Birth
Social Security Number* Home Phone Business Phone	Social Security Number* Home Phone Business Phone
Present address No. years:_____ ❑ Own ❑ Buying ❑ Rent	Present address No. years:_____ ❑ Own ❑ Buying ❑ Rent
Street: _____	Street: _____
City/State/Zip: _____	City/State/Zip: _____
Former address if less than 2 years at present address	Former address if less than 2 years at present address
Street: _____	Street: _____
City/State/Zip: _____	City/State/Zip: _____
Marital status:* ❑ Married ❑ Separated ❑ Divorced ❑ Widow ❑ Single	Marital status:* ❑ Married ❑ Separated ❑ Divorced ❑ Widow ❑ Single
Total number residing in household: _____	Total number residing in household: _____
Number of dependent children: _____ Ages: _____	Number of dependent children: _____ Ages: _____
Name and address of employer	Name and address of employer
Position/Title: _____ Length of employment: _____	Position/Title: _____ Length of employment: _____
Previous employer(s) (within the last year)	Previous employer(s) (within the last year)

Supporting documentation is required for all responsible parties. Please provide copies of the documents listed below. Your application cannot be processed until these items are received. If you have no proof of income or no income, please include an additional page with an explanation.

- **Federal Tax Return** for last year and the year in which services were provided. If the tax return for the current year has not been filed, use last tax year.
- **Proof of income** for the current year and the year in which services were provided. Sources of income may include pay stubs, unemployment or disability checks, Social Security award letters and/or a pension letter.
- **Bank statement** including all transactions.

MONTHLY INCOME

	Guarantor	Co-applicant	Total
Gross earnings	$	$	$
Farm/Self employed			
Pensions			
Work compensation			
Interest/dividends			
Rental property income			
Disability/SSI			
Military income			
Child support			
Alimony			
Unemployment			
ADC/Food stamps			
Subsidized housing			
Total monthly household income:			

MONTHLY HOUSEHOLD EXPENSES

Mortgage/rent payment (Circle one)	$	Child care expense	$
Lot rent		Child support payment	
Federal withholding taxes: # Exemptions_____		Credit cards (Minimum payment)	
State withholding taxes		Other loan(s) payment	
401K/403B withholding		Meds/med. supplies	
Property taxes		Auto loan payment	
Utilities, telephone/cell phone, insurance premiums		Alimony payment	
Garbage pickup		Other	
Cable TV			
Food			
Total monthly household expenses:			$

ASSETS*		LIABILITIES	
Description	**Cash totals or market value**	**Description**	**Total owed**
Cash	$	Mortgage loans	$
Checking accounts	$	Name of financial institution:	
Name of financial institution:		Home owners insurance	
Savings accounts	$	If not included in mortgage	
Name of financial institution:		Auto loan	
Life insurance net cash/loan value		Vehicle licensing tax	
Real estate property assessed value		Credit cards	
Net worth of farm or business (attach business tax return)		List other loans and locations	
Retirement funds			
• Pensions/Annuity			
• IRAs/401K			
• Mutuals			
• Other			
Automobiles (make and year)		List medical co-pay/out of pocket expenses and/or patient responsibility	
Other assets (boats, motorcycles, campers and antiques) Blue Book/retail		Other:	
Total Assets	$	**Total Liabilities**	$

*Central City Medical Clinic and Fullerton Medical Clinic Patients - starred (*) items are optional. Assets, social security number, citizenship status, housing status and/or mental status are not considered when determining eligibility for the sliding fee discount program.

HEALTH COVERAGE INFORMATION

Is health insurance coverage available to you through an employer or any other source? Yes_____ No_____

Do you participate? Yes_____ No_____

- If yes, please provide the following: Effective date: _____

Name of the insurance company: _____

Address: _____

Subscriber and policy number: _____

- If no, why did you choose not to participate: _____

_____

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services rendered to me by Bryan Medical Center, Bryan Physician Network, Bryan Heart, Crete Area Medical Center or Merrick Medical Center. I also understand that if the information, which I submit is determined to be false, such a determination will result in a denial of providing services such as uncompensated services, and that I will be liable for charges for services provided.

IN YOUR OWN WORDS, DESCRIBE YOUR NEED FOR FINANCIAL ASSISTANCE

I hereby grant permission to those medical center personnel who are authorized to receive, release or act upon financial information contained herein. I hereby release the designated medical center personnel and all parties who supply information at the request of the medical center personnel, from liability for any acts, communications or disclosures which are made pursuant to such an investigation.

_____ _____

Signature (person making request) Date

For Questions or to Return this Application:

Select appropriate location to return form or call based on where you received care.

❑ **Bryan Medical Center, Crete Area Medical Center, Merrick Medical Center, Bryan Physician Network & Bryan Heart**

Mail to: Bryan Health, Attention: Patient Financial Services, 2300 S. 16th St., Lincoln, NE 68502-9907

Phone: 402-481-5791 or 1-877-577-9277; Fax: 402-481-5721

Email: PFS@bryanhealth.org

❑ **Kearney Regional Medical Center & Platte Valley Medical Clinic**

Mail to: Kearney Regional Medical Center, Attention: Financial Assistance Office, 804 22nd Ave., Kearney, NE 68845-2206

Phone: 308-455-8113 or 855-404-5766; Fax: 308-455-3950

Email: billing@kearneyregional.com

For Bryan Health Office Use Only

Savista Patient	
Medicaid Approved?	
If Denied, Why?	
FPL	