

## Application for Charity Care Assistance

Application for charity care assistance may be made in the Johnson County Hospital's business office. Our counselor will ask you or your family member to complete an application for charity care and will request information about monthly income, expenses, credit card and loan obligations and assets owned.

In addition, the counselor will ask for a copy of your or your family's most recent federal tax return as well as other documents.

In evaluating your application, Johnson County Hospital will consider your income, debts owed and assets owned. To be considered for charity care, you cannot have assets out of proportion with the assistance requested. Charity care is available to US Citizens and to legal, permanent residents of the United States.

Charity Care is given for hospital charges only. Arrangements to pay your Physician, Radiology, Specialty Clinic, DME, Pharmacy and all other professional services not provided by the Johnson County Hospital are not eligible.

*Please attach your income and asset verification to your completed application.*

Family Size	100%	75%	50%	25%
1	\$10,400	\$13,000	\$15,600	\$20,800
2	\$14,000	\$17,500	\$21,000	\$28,000
3	\$17,600	\$22,000	\$26,400	\$35,200
4	\$21,200	\$26,500	\$31,800	\$42,400
5	\$24,800	\$31,000	\$37,200	\$49,600
6	\$28,400	\$35,500	\$42,600	\$56,800
7	\$32,000	\$40,000	\$48,000	\$64,000
8	\$35,600	\$44,500	\$53,400	\$71,200
Additional Family Members Add	\$3,600	\$4,500	\$5,400	\$7,200

If you believe you may be eligible for the Charity Care Program or have questions regarding this service, please call the Financial Counselor at **402-335-3361** or **402-335-6354**.

# CHARITY CARE APPLICATION

Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

## Dependents of Applicant (LIST YOURSELF FIRST)

Name(s)	Relation	Sex	Date of Birth	Birthplace	Social Security#
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

If you or any member of the household is pregnant, list name \_\_\_\_\_ due date \_\_\_\_\_

Are you a U.S. Citizen? \_\_\_ Yes \_\_\_ No If No, Give Alien Status \_\_\_\_\_ and Number \_\_\_\_\_

U.S. Entry Date \_\_\_\_\_ Place of Entry \_\_\_\_\_ and Country of Origin \_\_\_\_\_

## EMPLOYMENT INFORMATION

Please list your or anyone in your household's present or last employer

Name	Employer	Position	Hire Date	End Date	Reason for Leaving

## CURRENT INCOME

Wage Earner Name	Employer	Hours per Week	Amount per Month* (Gross)

\*If paid more than once monthly please note how often per month.

Example: **\$350.00 every two weeks**

**OTHER INCOME**

	Yes	No	Date Applied	Amount per Month/Week (Gross)
SSI	_____	_____	_____	\$ _____
Social Security	_____	_____	_____	\$ _____
Pension	_____	_____	_____	\$ _____
Annuities	_____	_____	_____	\$ _____
Workmen's Compensation	_____	_____	_____	\$ _____
Unemployment Compensation	_____	_____	_____	\$ _____
Veteran's Benefits	_____	_____	_____	\$ _____
Military Allotment	_____	_____	_____	\$ _____
Sick/Disability Benefits	_____	_____	_____	\$ _____
Boarder/Roomer Income	_____	_____	_____	\$ _____
Rental Property Income	_____	_____	_____	\$ _____
Child Support/Alimony	_____	_____	_____	\$ _____
Other (type & source)	_____	_____	_____	\$ _____

**If you have no income, please explain how you have been meeting your needs.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ASSETS**

Do you or anyone in your household have any of the following?

**Cash on Hand** \_\_\_Yes \_\_\_No If Yes, amount \$ \_\_\_\_\_

**Bank or Credit Union Accounts** \_\_\_Yes \_\_\_No If Yes, complete below:

Name of Bank/Credit Union	Address	Account #	Type	Balance
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____
_____	_____	_____	_____	\$ _____

**Annuities, Trusts and/or Stocks & Bonds** \_\_\_Yes \_\_\_No If Yes, complete below:

Name of Company/Institution	Account Number	Number of Shares	Current Value
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

**Motor Vehicle(s) cars, motorcycles, trailers, campers, boats, etc.** \_\_\_Yes \_\_\_No

Type	Make	Model	Year	Registration#	NADA Value	Loan Balance	Equity
_____	_____	_____	_____	_____	\$_____	\$_____	\$_____
_____	_____	_____	_____	_____	\$_____	\$_____	\$_____
_____	_____	_____	_____	_____	\$_____	\$_____	\$_____

**Life Insurance:** \_\_\_Yes \_\_\_No If Yes, complete below:

Insured	Company Name	Effective Date	Face Value	Cash Value
_____	_____	\$_____	\$_____	\$_____
_____	_____	\$_____	\$_____	\$_____
_____	_____	\$_____	\$_____	\$_____

**Real Property:** \_\_\_Yes \_\_\_No If Yes, complete below:

(House, Land, Rental Property, etc.)

Location and Type of Property	Mortgage Holder	Current Loan Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Other Assets:** \_\_\_Yes \_\_\_No If Yes, please explain: \_\_\_\_\_

### MILITARY HISTORY

Were you or was anyone in your Household in the military service? \_\_\_Yes \_\_\_No

If Yes, dates of service: \_\_\_\_\_

Branch of Service: \_\_\_\_\_ Disabled Veteran: \_\_\_Yes \_\_\_No

Applied to: Sailor, Soldier, Marine Fund: \_\_\_Yes \_\_\_No If Yes, date of application: \_\_\_\_\_

Applied to: Veterans' Administration: \_\_\_Yes \_\_\_No If Yes, date of application: \_\_\_\_\_

### MEDICAL INSURANCE/BENEFITS

Person Covered	Source & Type	ID/Case Number	Effective Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

# EXPENSES

## RENT

Monthly/Weekly

Apartment/House \$ \_\_\_\_\_

Room and Board \$ \_\_\_\_\_

Room Only \$ \_\_\_\_\_

Other (explain) \$ \_\_\_\_\_

Rent includes (please check)

Hot water \_\_\_ Heat \_\_\_ Electric \_\_\_ Gas \_\_\_

## OWN

House \_\_\_\_\_

Condominium \_\_\_\_\_

Mobile Home \_\_\_\_\_

Other (explain) \_\_\_\_\_

Mortgage Expense \$ \_\_\_\_\_

Yearly Taxes \$ \_\_\_\_\_

## UTILITY EXPENSE

Heat/Electric/Gas \$ \_\_\_\_\_

Telephone \$ \_\_\_\_\_

Cable TV \$ \_\_\_\_\_

Water \$ \_\_\_\_\_

## CREDIT CARD DEBT

Creditor Monthly Payment

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

## OTHER MISCELLANEOUS HOUSEHOLD EXPENSES

(circle one)

Child Support/Alimony \$ \_\_\_\_\_ weekly/monthly/yearly

Car/Vehicle Loan \$ \_\_\_\_\_ weekly/monthly/yearly

Car/Vehicle Insurance \$ \_\_\_\_\_ weekly/monthly/yearly

Health Insurance \$ \_\_\_\_\_ weekly/monthly/yearly

Life Insurance \$ \_\_\_\_\_ weekly/monthly/yearly

Tuition/Student Loan \$ \_\_\_\_\_ weekly/monthly/yearly

Hospital/MD Expense \$ \_\_\_\_\_ weekly/monthly/yearly

Child Care \$ \_\_\_\_\_ weekly/monthly/yearly

Personal Loan \$ \_\_\_\_\_ weekly/monthly/yearly

Other (list) \$ \_\_\_\_\_ weekly/monthly/yearly

## APPLICANT'S RIGHTS AND RESPONSIBILITIES

1. I hereby request Charity Care from Johnson County Hospital.
2. I certify that all statements made by me on this application are true and correct, under penalty for false statement as provided by Johnson County Hospital's Charity Care Policy.
3. I understand that I have a right to appeal if I am dissatisfied with the Hospital's decision on my application.
4. I agree that the information provided by me on this application must be verified and agree to provide documentation as requested.
5. I authorize Johnson County Hospital to conduct an investigation to establish my eligibility, and give the hospital permission to obtain information necessary from, but not limited to, the following sources: banks, credit unions and other financial institutions, employers, medical providers, landlord, and other agencies such as the Department of Social Services, the Department of Labor, the Social Security and Veteran's Administration, and the Immigration and Naturalization Service.
6. I agree to complete the application process for any Third Party Benefits for which I may be eligible, including Health Insurance, Veterans Benefits, etc. Further, I agree to apply for and complete the application process for State Medical Aid.

Signature of Applicant	Date
Signature of Spouse/Interpreter/Witness	Date
Signature of Financial Counselor	Date

**MAIL TO:**

**Business Office Manager  
Johnson County Hospital  
P.O. Box 599  
Tecumseh NE 68450**