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, including your denial from Medicaid.

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	$12,760	$15,950	$19,140	$22,330
2	$17,240	$21,550	$25,860	$30,170
3	$21,720	$27,150	$32,580	$38,010
4	$26,200	$32,750	$39,300	$45,850
5	$30,680	$38,350	$46,020	$53,690
6	$35,160	$43,950	$52,740	$61,530
7	$39,640	$49,550	$59,460	$69,370
8	$44,120	$55,150	$66,180	$77,210
Additional Family Members Add	$4,480	$5,600	$6,720	$7,840

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**.

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
202 High Street
Tecumseh NE 68450