INSTRUCTIONS FOR COMPLETING APPLICATION FOR UNCOMPENSATED CARE

A. Fill out the application completely. The application will be conditionally denied, until the completed information is received. Please note that we must have verification of income from all sources listed on the application and for all family members shown as dependents.

B. Verification of income consists of the following:

1) Employed Person: The verification shall consist of a copy of the last year's tax return, copies of payroll check stubs and/or certified statement of income from your employer(s) for the past 3 months. The past 12 months may be helpful.

2) Farmers and Self-Employed Persons: Verification shall consist of a copy of last year's tax return. (Prior years' losses and depreciation are not applicable toward qualification.)

3) Unemployed and Disabled Persons: The verification shall consist of proof of income from past employment if unemployed less than 12 months; proof of income from unemployment compensation; disabled persons, proof of income from Social Security or any other type of disability income; and proof of income from past employment if disabled less than 12 months.

4) College Students: The verification shall consist of proof of income from student grants or stipends and proof of income from any employment, husband or wife, while a student, including summer employment.

C. If you have questions concerning the above instructions, please contact Martha Nelson (402-569-2451) at Niobrara Valley Hospital. If the information received is incomplete, the application will be returned requesting the additional information.

PLEASE RETURN WITHIN 10 DAYS

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

PATIENT NAME: _____ DATE OF SERVICE_____

I hereby request that Niobrara valley Hospital make a written determination of my eligibility for Uncompensated care at Niobrara Valley Hospital. I understand that the information I submit concerning my annual income and family size is subject to written verification by Niobrara Valley Hospital. I hereby authorize and instruct any person, agency, my employer, or any consumer or credit reporting agency to furnish Niobrara valley Hospital with any information in response to their financial inquiries. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of uncompensated services and that I will be liable for all services provided.

Date: _____ Person Making Request: _____

1. Name: _____ Spouse Name: _____
2. Address: _____ Address:_____
3. City: _____ City: _____
4. State: _____ Zip: _____ State: _____ Zip: _____
5. Occupation: _____ Occupation: _____
6. Employer: _____ Employer:_____
7. Address: _____ Address: _____
8. Family Size:

Name	Age	Relationship	Name	Age	Relationship

9. Type Of Health Insurance:_____

10. INCOME: (list all family income)	TOTAL FOR LAST 3 MONTHS	TOTAL FOR LAST 12 MONTHS
WAGES……	$_____	$_____
WAGES……	$_____	$_____
WAGES……	$_____	$_____
FARM OR SELF-EMPLOYMENT…… …….	$_____	$_____
PUBLIC ASSITANCE……	$_____	$_____
UNEMPLOYMENT COMPENSATION……..…	$_____	$_____
WORKMAN'S COMPENSATION……..….	$_____	$_____
ALIMONY……..……	$_____	$_____
CHILD SUPPORT……..……	$_____	$_____
PENSIONS……..….	$_____	$_____
MILITARY ALLOTMENT……	$_____	$_____
COLLEGE GRANTS (NOT LOANS)……..…	$_____	$_____
INCOME FROM DIVIDENED/INTEREST…….	$_____	$_____
INCOME FROM RENT……	$_____	$_____
OTHER……	$_____	$_____
OTHER……..……	$_____	$_____
TOTAL…..$	_____	$_____

I affirm that the above preceding information is true and correct to the best of my knowledge. Further, the undersigned hereby authorize Niobrara Valley Hospital to contact any credit reporting agency or any other credit references for the purpose of obtaining a consumer credit report for evaluation creditworthiness in connection with this application.

Date:_____ Signature:_____

Date Received: _____ Signature: _____