JEFFERSON COMMUNITY
Health & Life

Application for Financial Assistance

Name_____ Social Security Number_____ Date of Birth_____
(optional)

Spouse Name_____ Social Security Number_____ Date of Birth_____
(optional)

Address_____ Phone Number_____

City, State, Zip_____ Cell Phone_____

Dependents' Name_____ DOB_____ Dependents' Name_____ DOB_____

Dependents' Name_____ DOB_____ Dependents' Name_____ DOB_____

Self
Employer_____

Address_____

Phone Number_____

Monthly Gross Income_____

Other Monthly Income_____

Other Monthly Income_____

Spouse
Employer _____

Address_____

Phone Number_____

Monthly Gross Income_____

Other Monthly Income_____

Other Monthly Income_____

(Welfare, SSI, Child Support, Workman's Comp., Unemployment, Pensions, Rents, Alimony, Veteran's Survivor Benefits, Retirement)

Do you have a Health Savings Account (HSA) and/or Flexible Spending Account? Yes No

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, Medicare, Insurance, etc.) which may be available for payment of my hospital charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for such charges. I understand that the information given is to be used to ascertain my ability to pay for the services provided by Jefferson Community Health & Life. I hereby grand permission to Jefferson Community Health & Life to investigate the information contained therein.

Self
Signature_____

Date_____

Spouse
Signature_____

Date_____

Please attach copies of W-2s, current tax return or paystubs for at least three months prior to this application for all working members in your household. Failure to do so will result in denial of application. Please print completed form and mail or deliver to: Attn: Business Office, Jefferson Community Health & Life, 2200 H Street, Fairbury, NE 68352