

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 Spouse
Employer _____ Employer _____

Address _____ Address _____

Phone Number _____ Phone Number _____

Monthly Gross Income _____ Monthly Gross Income _____

Other Monthly Income _____ Other Monthly 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 grant permission to Jefferson Community Health & Life to investigate the information contained therein.

Self Spouse
Signature _____ Signature _____

Date _____ 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