

ALEGENT Health
FINANCE DIVISION
FINANCIAL ASSISTANCE APPLICATION

Immanuel Bergan Midlands Mercy Lakeside Missouri Valley

Hospital Use

Account Number		MR Number	
Patient Name			Date of Birth
Responsible Party		Social Security Number	Home Phone
Address		City	State
			Zip Code
Employer		FT/PT Work Number	Monthly Gross Income
Spouse's Name		Social Security Number	Monthly Gross Income
Employer		FT/PT Work Number	
Responsible Party's Other Income		Spouse's Other Income	
Family Size	Annual Gross Household Income		Ages of Dependent Children
		Name of Children	

PROOF OF INCOME: A COPY OF THE FOLLOWING INFORMATION MUST ACCOMPANY YOUR APPLICATION IN ORDER TO PROCESS

Federal Tax Return (most recent) **REQUIRED** **Self Employed Applicants:**
 Current Pay Stub (Responsible Party and Spouse) **REQUIRED** Please provide last 2 complete Federal Tax Returns with profit and loss reportings **REQUIRED**

****Your application cannot be considered without the above information****

Other Income Source Documentation

- | | | | | | |
|--|--|--|---|--|--|
| <input type="checkbox"/> Social Security (earnings record) | <input type="checkbox"/> VA Assistance | <input type="checkbox"/> Railroad Retirement | <input type="checkbox"/> Child Support | <input type="checkbox"/> Disability | <input type="checkbox"/> Life Insurance |
| <input type="checkbox"/> Pension | <input type="checkbox"/> Alimony | <input type="checkbox"/> Unemployment | <input type="checkbox"/> Workman's Comp | <input type="checkbox"/> Public Assistance | <input type="checkbox"/> Other: Please List: |

ASSETS

Cash on hand (include checking) \$ _____
 Savings \$ _____
 Stocks/Bonds/Retirement Funds \$ _____

 Model _____ Year _____ \$ _____
 Model _____ Year _____ \$ _____
 Home: Estimated Market Value \$ _____
 Other Assets \$ _____
 Other Assets \$ _____
Total Assets: \$ _____
Net Worth (Assets-Liabilities) \$ _____

LIABILITIES AND NET WORTH

Bank Loans \$ _____
 Total Credit Cards \$ _____
 Home Mortgage
 Rent Own
 Other Liabilities \$ _____
 Other Liabilities \$ _____
Total Liabilities: \$ _____

FIXED MONTHLY EXPENSES

House Payment/Rent \$ _____
 Utilities \$ _____
 Telephone \$ _____
 Cable TV \$ _____
 Medical Bills \$ _____
 Prescription Drugs \$ _____
 Insurance \$ _____
 Groceries \$ _____
 Child Care \$ _____ Child Support \$ _____
 Other \$ _____ \$ _____
Total Monthly Expenses \$ _____

I hereby acknowledge that the information given to Alegent Health is true and correct to the best of my knowledge. I authorize Alegent Health to verify any or all the information given and to obtain a consumer credit report, to be obtained as deemed necessary.

Patient/Guarantor's Signature	Date
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*******PROOF OF INCOME REQUIRED*****You may be required to complete a new form for each date of service*******

If you have any questions regarding this form, please contact a Financial Counselor at 402-717-7888, Monday through Friday at 8 a.m. to 5:30 p.m.