Antelope Memorial Hospital
Healing Body, Mind and Spirit

INSTRUCTIONS FOR COMPLETING APPLICATION FOR UNCOMPENSATED CARE

A. Fill out the application completely. The application will be considered incomplete until all requested 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 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.) A personal financial statement is attached and must also be completed for all family members shown as dependents.

   2) Farmers and Self-Employed Persons: Verification shall consist of a copy of last year's tax return. (Prior years' losses are not applicable toward qualification.) Any and all depreciation expense incurred in calculating total income shall be disregarded. A personal financial statement is attached and must also be completed for all family members shown as dependents.

   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. A personal financial statement is attached and must also be completed for all family members shown as dependents.

   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. A personal financial statement is attached and must also be completed for all family members shown as dependents.

   If you have questions concerning the above instructions, please contact the Patient Financial Counselor at 402-887-6286. If the information received is incomplete, the hospital will provide the patient with written notice.

PLEASE RETURN WITHIN 10 DAYS

Antelope Memorial Hospital
Healing Body, Mind and Spirit

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR
UNCOMPENSATED SERVICES

PATIENT NAME: _____ DATE OF SERVICE: _____

I hereby request that Antelope Memorial Hospital make a written determination of my eligibility for Uncompensated Care at Antelope Memorial Hospital. I understand that the information I submit concerning my annual income and family size is subject to written verification by Antelope Memorial Hospital. I hereby authorize and instruct any person, agency, my employer, or any consumer or credit reporting agency to furnish Antelope Memorial 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. PERSONAL FINANCIAL STATEMENT

Date of valuation

***** Attach separate sheet if you need more space to complete detail schedule

Assets (assets you own)	Amount		Liabilities (debts you owe)	Amount
Cash in this bank: Checking			Loans payable to banks (schedule 7)	$ -
Savings			Loans payable to others (schedule 7)	
C.D.'s			Installment contracts payable (schedule 7)	
IRA			Amounts due to dept. stores and others	
Cash in other banks			Credit cards (MasterCard, Visa & others)	
Due from friends, relatives and others (schedule 1)	$ -		Income taxes payable	
Mortgage and contracts for deed owned (schedule 2)	$ -		Other taxes payable	
Securities owned (schedule 3)	$ -			
Cash surrender value of life insurance (schedule 4)	$ -		Loans on life insurance (schedule 4)	$ -
Homestead (schedule 5)	$ -			
Other real estate owned (schedule 5)	$ -		Mortgage on homestead (schedule 6)	$ -
Automobiles (year, make, model)			Mortgage or liens on other real estate (schedule 6	$ -
Personal Property				
			Other liabilities (detail)	
Other assets (detail)				
			TOTAL LIABILITIES	$ -
			Net worth (total assets less total liabilities)	**$** -
TOTAL	$ -		TOTA	$ -

Annual Income	Applicant	Joint Applicant	Contingent liabilities	Amount
Salary			As endorser	
Commissions			As guarantor	
Dividends			Lawsuits	
Interest			For taxes	
Rentals			Other (detail)	
Alimony, child support or separate maintenance income				
received under ____ Court Order ____ Written Agreement				
____ Oral Understanding (You need not reveal this income if				
you do not wish to have it considered as a basis for repaying				
this obligation)				
Other			o *Check here if "none"*	
TOTAL INCOM	$ -	$ -	TOTAL CONTINGENT LIABILITIES	$ -

SCHEDULE 1 DUE FROM FRIENDS, RELATIVES and OTHERS

Name of debtor	Owed to	Collateral	How payable	Maturity Date	Unpaid balance
			per		
			per		
			per		
				TOTAL	$ -

SCHEDULE 2 MORTGAGE AND CONTRACTS FOR DEED OWNED

Name of debtor	Type of property	1st or 2nd lien	Owed to	How payable	Unpaid balance
				per	
				per	
				TOTAL	$ -

SCHEDULE 3 SECURITIES OWNED

No. shares or Bond amount	Description	In whose name(s) registered	Cost	Present Market Value	L- listed U- unlisted
		TOTAL	$ -	$ -	

SCHEDULE 4 LIFE INSURANCE

Insured	Insurance Company	Beneficiary	Face value of policy	Cash value	Loans
			TOTAL	$ -	$ -

SCHEDULE 5 REAL ESTATE

Address and Type of Property	Title in name(s) of	Monthly Income	Cost / Year Acquired	Present Market Value	Amount of Insurance
Homestead			$ - Year		
			$ - Year		
			$ - Year		
			$ - Year		
			$ - Year		

SCHEDULE 6 MORTGAGES OR LIENS ON REAL ESTATE

To Whom Payable	How Payable	Interest Rate	Maturity Date	Unpaid Balance
Homestead	$ - per			
	$ - per			
	$ - per			
	$ - per			
	$ - per			

SCHEDULE 7 LOANS PAYABLE TO BANKS & OTHERS AND INSTALLMENT CONTRACTS PAYABLE

To Whom Payable	Address	Collateral or Unsecured	How Payable	Maturity Date	Unpaid Balance
			$ - per		
			$ - per		
			$ - per		
			$ - per		

I affirm that the above preceding information is true and correct to the best of my knowledge. Further, the undersigned hereby authorize Antelope Memorial Hospital/AMH Family Practice 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: _____

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Date Received: _____ Signature: _____

Policy approved 11/29/2016