OrthoNebraska Financial Assistance Application

Patient Name _____ Med Record # _____

Patient SS # _____ Date of Birth _____

Home Address _____ Phone # _____

Spouse Name _____ Spouse SS# _____

Name, address and policy number of insurance carrier:

Name _____ Address _____ Policy Number _____

List your dependents & date of birth			
	/ /	/ /	/ /

Combined current household gross annual income: $ _____

Proof of income: A copy of the following information must accompany your application:

1. Most Current Federal Tax Return 2. Last 3 Pay Stubs (all incomes) 3. 3 Months Detailed Bank Statements

4. Other income sources documentation: Social Security, Disability, Unemployment, VA Assistance, Workman's Comp, Railroad Retirement, Pensions, Public Assistance, Other retirement, Child Support, Alimony

Patient Employer(s) Name _____

Paid $ _____ ○ Weekly ○ Bi-Weekly ○ Monthly ○ Other

Spouse Employer(s) Name _____

Paid $ _____ ○ Weekly ○ Bi-Weekly ○ Monthly ○ Other

Assets _____

Please list out Cash on Hand, Savings Accounts, Stocks & Bonds Market Value, IRA's, etc.

Liabilities: Please provide the monthly payment amounts and balance due

Rent/Mortgage Payment _____ Credit Union _____

Personal Loans _____ Charge Acc'ts _____

Finance Companies _____ Bank Loans _____

Auto Insurance _____ Utilities _____

Health Insurance _____ Child Care _____

Medical Expenses _____ Phone & Cable _____

Collection Agencies _____ Food _____

IF NO INCOME, PLEASE DOCUMENT HOW YOU SUPPORT YOURSELF

Have you or your guarantor applied for assistance from any other source?

Medicaid _____ County _____ Disability _____ Other _____

I certify that all information listed herein is true and correct to the best of my knowledge. I understand that the information is to be used to ascertain my ability to pay for services, which are rendered to me by OrthoNebraska. I hereby grant permission to OrthoNebraska personnel authorized to receive, release, or act upon financial information, to investigate the information contained herein. Investigation shall include the contacting, by written communication or telephone, of those persons, firms, corporations, etc noted by you on this financial information document. Investigation may also include a credit check. I hereby release the designated physician personnel and all parties who supply information at the request of the physician personnel from liability for any of commission or omission, communications of disclosures that are made pursuant to such an investigation. I understand that submission of false information will automatically disqualify me for any type of assistance.

Guarantor Signature _____ Date _____

Spouse Signature _____ Date _____

Mail to: OrthoNebraska
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