TRI VALLEY HEALTH SYSTEM

P.O. Box 488
Cambridge, NE 69022

Cambridge Memorial Hospital • Cambridge Medical Clinic
Arapahoe Medical Clinic • Indianola Medical Clinic

Financial Assistance Application

Thank you for choosing Tri Valley Health System to meet your health care needs. We hope you found our service to be of the highest quality. Please complete the attached financial application to determine if you are eligible for assistance. We will need the following in order to complete your application:

1. W2 forms for each member of the household
2. Income tax returns for all household members for the past two years (Please include every page)
3. Current or most recent employment pay stubs for all household members for the past three months
4. Bank statements for all household members for the past three months
5. Copy of rent or mortgage payment

Failure to provide all documents will result in an incomplete application, which may result in the individual(s) being denied assistance under this policy. If you are unable to provide certain documents, please note explanation. **Application is due within 30 days.**

Please return the completed application to the address listed above, attention Patient Financial Counselor. After your application is reviewed, you will receive verbal and/or written notification of the decision made.

Please feel free to contact us at (308) 697-1512 if you have any questions or concerns.

Sincerely,

Patient Financial Counselor
Tri Valley Health System

TRI VALLEY HEALTH SYSTEM

P.O. Box 488
Cambridge, NE 69022

Financial Assistance Application

This financial application is designed to assist us in determining a reasonable payment plan or financial assistance for the services rendered to you and/or your family. Please complete each inquiry on the application. If an inquiry does not apply to you, please respond by writing N/A in the blank. Please provide copies for the past three months of paycheck stubs for everyone working in your household and bank statements for everyone living in the household, as well as a copy of your rent or house payment receipt and a copy of your two most recent income tax returns. All information given on this application if confidential and will be treated as such. Thank you for your cooperation.

Guarantor Name: _____ Date: _____

Mailing Address: _____

Physical Address (if different from mailing): _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Guarantor's Employer: _____ Spouse's Employer _____

Number of Adults in Household: _____ Number of Children in Household: _____

Guarantor's Monthly Income: _____ Spouse's Monthly Income: _____

Social Security: _____ Pension: _____ Other (Child Support, Rental Income, Etc):_____

Total Monthly Income: _____

Monthly Expenses

Rent/House Payment: _____ Phone/Cable: _____ Gas/Electric: _____

Auto (Gas/License): _____ Groceries: _____ Medical: _____

Insurance (House, Auto, Life): _____ Property Tax: _____ Other: _____

Loans

To Whom	Payment Amount	Balance
_____	_____	_____
_____	_____	_____

_____ _____ _____

Assets

Real Estate

House: _____ **Location: _____**

Land: _____ **Location: _____**

Vehicles

Year: _____ **Make: _____**

Year: _____ **Make: _____**

RV/Boat/Trailer

Year: _____ **Make: _____**

Year: _____ **Make: _____**

Bank Accounts

Checking: _____ Bank: _____

Checking: _____ Bank: _____

Savings: _____ Bank: _____

Savings: _____ Bank: _____

Certificate of Deposit: _____ Bank: _____

Other

Cash Value of Life Insurance: _____ Company: _____

Other Investments: _____ Description: _____

I certify that the information given on this application is true and correct to the best of my knowledge.

Guarantor Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____

Disclosure: No one will be denied access to services due to an inability to pay, and a sliding fee scale is available based on family size and income if requested. Asset testing is not required for the Medicare certified Rural Health Clinics.