Children's Nebraska offers Financial Assistance to patients whose primary residence is in Nebraska, Iowa, or South Dakota. Eligibility for assistance is based on gross household income. As part of the application process, individuals who appear eligible for government assistance programs, including Medicaid, may be required to apply for those programs before Financial Assistance can be considered. This application is used for financial assistance with services provided by Children's Nebraska Hospital, Children's Specialty Physicians, Children's Physicians, and Children's Home Healthcare.

Instructions: Fill out the entire application. If a section does not apply to you, write "N/A." Missing information or documents may delay processing of your application or cause it to be denied.

The following documents are required to be submitted with your application:

☐Most recent Federal Tax Return (IRS Form 1040), including all pages and schedules (this is different from a W-2), If you are self-employed, your tax return will be used to verify income.

☐ Most recent W-2 Form(s) from all employers, if applicable, showing earnings and taxes withheld. A W-2 is different from a Federal Tax Return (IRS Form 1040).

☐Most Recent 2 Months of bank and/or health savings statements for all accounts held by you and/or your spouse/partner, including all pages and transactions (checking, savings, health savings account, flexible savings account).

☐ Most recent pay stubs for a full month from all individuals with income. For example: if paid weekly, provide 4 pay stubs; if paid every two weeks, provide 2 pay stubs; if paid monthly, provide 1 pay stub. If you changed employers during the current calendar year, please provide the final pay stub from each previous employer, in addition to one full month of pay stubs from your current employer.

☐ Child Support (If Applicable): You may provide documentation from the state or child support court order showing the child support amount and payment frequency.

☐ Other Sources of Income (i.e. Alimony, SNAP, WIC, LIHEAP, SSI, SSDI) (If Applicable): You may provide documentation from an award letter or divorce decree.

Please return the completed application and all supporting documentation to:

Email: cbopatientadvocates@childrensnebraska.org

Mail: Central Billing Office/Financial Advocates
PO Box 247036
Omaha NE 68124-7036

Fax: 402.955.6850

Online: You can also apply online through Children's Connect.

Application for Financial Assistance

Name of Responsible Party (The "Responsible Party" is the patient or patient's legal guardian who signed the consent for services provided.)	
Address:	Household Size: (All individuals living at the same address)
City, State Zip:	
Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐ Unemployed Current employment start date (Month, DD, YYYY): Unemployment start date to end date (Month, DD, YYYY): (If applicable)	
Employers Name:	
Monthly Gross Income: $	
Frequency Of Pay: ☐Weekly (paid every week) ☐Biweekly (paid every 2 weeks) ☐Semi-Monthly (paid 2 times per month) ☐Monthly (paid 1 time per month)	

Name of Spouse/Partner:	
Address:	
City, State Zip:	
Employment Status: ☐Full Time ☐Part Time ☐Self Employed ☐ Unemployed Current employment start date (Month, DD, YYYY): Unemployment start date to end date (Month, DD, YYYY): (If applicable)	
Employers Name:	
Monthly Gross Income: $	
Frequency Of Pay: ☐Weekly (paid every week) ☐Biweekly (paid every 2 weeks) ☐Semi-Monthly (paid 2 times per month) ☐Monthly (paid 1 time per month)	

Other Sources of Income	Monthly Amount
Child Support	$
Alimony	$
SNAP/WIC/LIHEAP	$
Social Security (SSI, SSDI)	$
Other Sources (specify)	$

Dependents (Under Age 19): List all minor children living in your household. **(**If more than 4 dependents use a separate page)

Full Name	Relationship	Date of Birth

Other Household Members (Age 19 and Older)
List all adults who live in your household, including relatives, adult children, roommates, or others who contribute to household income or expenses.

Full Name	Relationship to patient	Date of Birth

Monthly Expenses
Rent or Mortgage: $
Utilities (Electric, Gas, Water): $
Food: $
If the household has no income is anyone assisting, you with your monthly expenses? ☐ Yes ☐No If yes, Name of the person providing support: Relationship: Monthly amount provided:

I certify that all information provided in this application and supporting documents is true, complete, and accurate to the best of my knowledge. I authorize Children's Nebraska to verify the information provided and obtain any necessary information to determine eligibility for financial assistance. I understand that missing or incorrect information may delay the review of my application or result in a denial of assistance.

Printed Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____