Understanding Financial Assistance

Methodist Health System's financial assistance program is designed to serve those in financial need with fairness, consistency and compassion.

If you have difficulty paying your bill for services, our financial counselors will work with you to identify and explain the options available. This service is free and confidential.

We do require your participation in the process, including a completed application form with current financial information. The information that you provide will be verified and used to evaluate your ability to pay your bill.

Those who qualify for financial assistance will receive a specific discount on the bill, up to a 100 percent discount for charity care.

We will look at:

- Your financial resources.
- Your current and/or expected expenses for health care services at Methodist Health System affiliates.
- Your debts or liabilities, including expenses for other health care services, housing, transportation, etc.
- Any third-party payer resources, including private insurance and government assistance programs.

It is important to remember that you may be eligible for existing federal or state government entitlements or other assistance programs. Financial assistance from Methodist Heath System is not a substitute for these programs. Our counselors can help you with the enrollment process for government services and subsidies.

If you do not qualify for financial assistance or charity care from Methodist Health System and still need assistance in paying your bill, our financial counselors can explain these additional options:

- Limited monthly payment plan
- Low interest bank loans

Methodist Health System cannot provide financial assistance (discounted or charity care) for dental care, prescription drugs, eyeglasses or other non-acute/non-physician health care services.

For More Information

To learn more about financial assistance from Methodist Health System, call the appropriate Customer Service office listed below. A financial counselor can answer your questions and help you with the application process.

Office hours are Monday–Friday, 8 a.m. – 4:30 p.m. or visit www.bestcare.org/financialassistance.

Methodist Hospital
Methodist Jennie Edmundson Hospital
Methodist Women's Hospital

P.O. Box 2797
Omaha, NE 68103-2797
(402) 354-4230
(888) 485-4494 Fax: (402) 354-6171

Methodist Physicians Clinic

P.O. Box 3755
Omaha, NE 68103-0755
(402) 354-2100
(888) 852-4480 Fax: (402) 354-6171

Payment Options

We accept cash, personal checks, Visa, MasterCard, Discover or American Express.

For Online Bill Pay use bestcare.org

Methodist Health System and Affiliates

Application for Financial Assistance

METHODIST HEALTH SYSTEM

The meaning of care.®

Methodist Health System Financial Assistance Application

Internal Use Only ❑ Methodist Hospital ❑ Methodist Jennie Edmundson Hospital ❑ Methodist Physicians Clinic

Patient Account Number: _____

Patient Name: _____ Date of Birth: _____

Responsible Party: _____ SSN: _____

Home Phone:_____ Cell Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ FT/PT Work Number: _____

Monthly Gross Income: $_____ Length of Employment_____

Spouse's Name: _____ SSN: _____ 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: _____

The Following Proof Of Income Is Required To Process Your Application:

✔ Federal Tax Returns (last years) ✔ Current Pay Stub (Responsible Party and Spouse)

Other Income Source Documentation

❑ Social Security Insurance ❑ VA Assistance ❑ Railroad Retirement
❑ Child Support ❑ Disability ❑ Life Insurance
❑ Pension ❑ Alimony ❑ Unemployment
❑ Workers Comp ❑ Public Assistance
❑ Other: Please List _____

I certify that all information in this application is true and correct to the best of my knowledge, and I give Methodist Health System permission to investigate the information provided. I understand that the information will be used to evaluate my ability to pay for services provided by Methodist Health System. I also understand that when the evaluation is completed, I will have 30 days to pay the remaining balance in full or my account may be listed with an outside collection agency.

Patient/Responsible Party Signature: _____ Date: _____

PROOF OF INCOME IS REQUIRED. If you have questions about this form, call Customer Service, Monday – Friday, 8 a.m. – 4:30 p.m. Phone numbers are listed on the reverse side of this application.

ASSETS

Cash on hand (including checking)	$_____
Savings	$_____
Stocks/Bonds/Retirement Funds:	$_____
Car(s)	
Model: _____ Year: _____	$_____
Model: _____ Year: _____	$_____
Home: Estimated Market Value	$_____
Other Assets: _____	$_____
Other Assets: _____	$_____
Total Assets	$_____
Net Worth (Assets – Liabilities)	$_____

LIABILITES AND NET WORTH

Bank Loan(s)	$_____
Total Credit Cards	$_____
Home Mortgage	$_____
❑ Rent ❑ Own	
Other Liabilities: _____	$_____
Other Liabilities: _____	$_____
Other Liabilities: _____	$_____
Total Liabilities:	$_____

FIXED MONTHLY EXPENSES

Medical Bills	$_____
Prescription Drugs	$_____
Other	$_____
Total Monthly Expenses	$_____