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 team will work with you to identify and explain the options available. This service is free and confidential.

We do require your participation, including a completed application form and financial documents. Information provided will be used to evaluate your ability to pay your bill.

There may be an option to complete an application over the phone. Call customer service for more details.

Those qualifying for assistance will receive a specific discount (up to a 100% discount for charity care).

We will review:

- Gross family income, assets and family poverty level to determine assistance
- Your expenses for health care services at Methodist Health System affiliates
- Your debts at other health care facilities
- Third-party payer resources, including private insurance and government assistance programs

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

Firstsource

Methodist Women's Hospital – (402) 815-1117
Methodist Hospital (402) 354-6558
Methodist Jennie Edmundson (712) 396-7297
Methodist Fremont Health (402) 727-3549

Patients are responsible for copayments at the time of service on any visit.

If you have questions about this form, visit **bestcare.org/financialassistance** or call (402) 354-4230. Customer support is available Monday-Friday, 8 a.m.-5 p.m.

For online bill pay, visit **bestcare.org/billpay**.

PLEASE READ THE FOLLOWING BEFORE SIGNING AND DATING OTHER SIDE OF APPLICATION.

- You will continue to receive a monthly statement while your application is being reviewed.
- Proof of income is required.
- I certify that the information I have provided 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 and for any other lawful business purposes of Methodist Health System.
- I understand that when the evaluation is completed, I will have 30 days to make arrangements on the remaining balance or my account may be listed with an outside collection agency.

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Methodist Health System Application for Financial Assistance

Methodist Hospital
Methodist Women's Hospital
Methodist Physicians Clinic
Methodist Jennie Edmundson Hospital
Methodist Fremont Health

Methodist Health System Financial Assistance Application

Please mail completed application to Methodist Health System, PO Box 2797, Omaha, NE 68103-2797

Patient Account Numbers____

IMPORTANT: This application may not be processed if income documentation is not received.

Please submit the following required documentation with this completed and signed application:

- ☐ Copy of tax return IRS form 1040 from most recent tax year including all Schedules, W2s, 1099s, and Schedule C (self-employed)
- ☐ Copy of most recent pay stub for self and spouse
- ☐ If Social Security income: Copy of Social Security letter or bank statement showing most recent Social Security deposit
- ☐ If unemployed: Copy of compensation received, unemployment or workers compensation
- ☐ Copy of 2 months of bank statements (checking, savings, money market, etc.)
- ☐ If self-employed, copy of 2 months personal and business bank statements
- ☐ If reporting $0 income, attach a letter of support explaining situation/description of how basic needs being met

Patient/ Applicant Information:

First Name	Middle Initial	Last Name	Date of Birth	Social Security#	Email Address

Street Address/ PO Box	Apt#	City	State	Zip Code	Daytime Phone#

Spouse/ Child/ Dependent Information: Use additional sheet of paper if needed.

First & Last Name	Relationship	Date of Birth	First & Last Name	Relationship	Date of Birth
1.			3.		
2.			4.		

Employment Income - Documentation Required:

Patient/Applicant Employer: ____________________ Gross Monthly Income: $__________ Length of Employment: ________

If **Unemployed,** Date of unemployment: (Month, DD, YYYY) __________ What was your income prior to unemployment? $__________

If **Self-Employed,** provide assets of your business of your business/company/products etc $____________________

Spouse Employer: Gross Monthly Income: $ ____________ Length of Employment: ____________

If **Unemployed,** Date of unemployment: (Month, DD, YYYY) __________ What was your spouse's income prior to unemployment?$______

Other Income Source ***(please indicate amount received monthly and provide documentation):***

Social Security Pension$__________ Alimony$__________ Unemployment$__________ Workers Comp$_________

VA Assistance$ ________ Retirement$__________

Circle if currently receiving Public Assistance: SNAP / WIC **(provide documentation)**

Assets - Documentation Required: Cash and Checking$ ___________ Savings$ ____________ Money Market$ ___________

CDs$ __________ Stocks / Bonds$ ____________ Investment accounts (non-retirement)$ ____________

Real Estate *(other than primary residence)* Value$ ____________ Address of Property: ______________________________

Liabilities/ Monthly Expenses: Other Healthcare bills/Pharmacy$__________ month, Total owed:$______________

** ***Please sign and date*** ** Signature (Applicant/ Guarantor) ______________________________ Date: ____________

Confidentiality Notice: The documents accompanying this transmission may contain confidential or legally privileged information. If you are not the intended recipient, any disclosure or distribution is strictly prohibited. If you are not the intended recipient, please notify the sender immediately and destroy these documents.

NOT PART OF PERMANENT MEDICAL RECORD