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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 one of the customer service phone numbers listed in the brochure for more details.

Those qualifying for assistance will receive a specific discount on the bill, up to a 100% discount for charity care.

We will review:

- Your financial resources.
- 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 is 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 MASH program can assist you with the enrollment process for government services and subsidies.

MASH (Medical Advocacy Services for Healthcare)
Women's Hospital – 402-815-1117
Methodist Hospital – 402-354-4740
Jennie Edmundson – 712-396-7246

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Patients are responsible for co-payments at time of service on any visit...

If you have questions about this form, call Customer Support Monday – Friday, 8 a.m. – 5 p.m. or visit www.bestcare.org/financialassistance.

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

For Online Bill Pay use
www.bestcare.org/billpay

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

- 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 pay the remaining balance in full or my account may be listed with an outside collection agency.

®Revised 06/2020

Methodist Health System and Affiliates

Application for Financial Assistance

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 Fremont Health

Attn: Patient Financial Services
450 East 23rd Street
Fremont, NE 68025-2387
(402) 941-7224
Fax: (402) 941-2430

Methodist Physicians Clinic

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

METHODIST HEALTH SYSTEM

The meaning of care.®

Methodist Health System Financial Assistance Application

Patient Account Numbers: _____

IMPORTANT: *Supporting documentation that verifies household income is required to qualify for financial assistance. Documentation can include but is not limited to: most recent year's Federal Tax Return including all Schedules, a current W-2 / 1099 forms, 1 month of current Pay-stubs, signed letter of support, approval for Public Assistance, Social Security benefit letter, etc.*

Patient Information:

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

Street Address | City | State | Zip Code | Phone # | Work Phone #

Spouse / Guarantor / Responsible Party information (if different from patient):

Last Name | First Name | Middle Initial | Social Security # | Date of Birth | Relationship to Patient | Email Address

Street Address | City | State | Zip Code | Phone # | Work Phone #

Household Information:

Please indicate all people living in household, including applicant. ***Use additional sheet of paper if needed.***

Name | Relationship | Date of birth | Name | Relationship | Date of birth

Name | Relationship | Date of birth | Name | Relationship | Date of birth

Name | Relationship | Date of birth | Name | Relationship | Date of birth

Employment / Household Income and Expenses:

Patient/Guarantor Employer: _____ Gross Monthly Income: $ _____ ***(Provide documentation)***

Length of Employment: _____ Work Phone #_____ If Self-Employed, provide assets of your company $_____

If income is $0, please explain: _____

Spouse Employer: _____ Gross Monthly Income: $ _____ ***(Provide documentation)***

Length of Employment: _____ Work Phone #_____ If Self-Employed, provide assets of your company $_____

If income is $0, please explain: _____

Other Income Source (please indicate amount received and provide documentation): Social Security $_____

Alimony $_____ Unemployment $_____ Pension $_____ Workers Comp $_____ VA Assistance $_____

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

Assets: Cash and Checking $ _____ Savings $ _____ Money Market $ _____ CDs $ _____ IRA $ _____

Stocks / Bonds $_____ Retirement accounts (403b, 401k) $ _____ Investment accounts (non-retirement) $_____

Other Assets: _____ $ _____ Real Estate (other than primary residence): Value $ _____

Address of Property: _____ ***Use additional sheet of paper if more than one property.***

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

***** Please sign and date ***** **Signature (Applicant/Guarantor)** _____ **Date** _____

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