Sidney Regional MEDICAL CENTER

Mailing Address: 1000 Pole Creek Crossing, Sidney, NE 69162
Physical Address: 645 Osage Drive, Sidney, NE 69162

In order for us to evaluate the solution that best fits your financial situation, please complete the below questions to determine our next steps.

This application must be returned within 30 days.

Please contact us with any questions or concerns you may have at 308-254-8778. We are here to help.

~YOUR PATIENT ACCOUNT SPECIALIST TEAM

SECTION I

Check if this applies to you:

☐ Ages 19 through 64 and meet the following income criteria:

Household Size	Annual Income is Less Than	Household Size	Annual Income is Less Than
1	20,030	6	55,807
2	27,185	7	62,962
3	34,341	8	70,118
4	41,496	9	75,498
5	48,651	10	80,878

*Effective 1/1/24 – Subject to Change

If you checked the above box, SKIP TO APPLY FOR MEDICAID SECTION III. If not, continue to Section II.

SECTION II

Check any that apply to you:

☐ 65 years or older
☐ Under 65 and have a disability or visually impaired, according to Social Security Guidelines
☐ 18 years or younger
☐ A pregnant woman
☐ A parent or caretaker
☐ A former foster care youth (no income criteria) between ages 19-25, active on Medicaid at the time they aged out, and was in Nebraska foster care.
☐ Medically frail health condition. Meeting any of the following criteria: Disabling mental health condition; a chronic substance use disorder; a physical, intellectual, or developmental disability with functional impairment that significantly impairs an individual from performing one or more activities of daily living each time the activity occurs; a disability determination based on Social Security Criteria; a serious and complex medical condition; or chronically homeless as defined by the United States Department of Housing and Urban Development.

If you checked any of the above boxes, CONTINUE TO THE APPLY FOR MEDICAID SECTION III AND COMPLETE SECTION IV.

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SECTION III

APPLY FOR MEDICAID

- Apply online at www.ACCESSNebraska.ne.gov
- Apply over the phone by calling ACCESS Nebraska at
  - Omaha: (402) 595-1178
  - Lincoln: (402) 473-7000
  - Toll Free: (855) 632-7633
  - TDD: (402) 471-7256
- Apply by paper application (which may be downloaded from AccessNebraska.gov)
  - Faxed to (402) 742-2351
  - E-mailed at DHHS.ANDICenter@nebraska.gov
  - Sent by mail to P.O. Box 2992, Omaha, NE 68103-2992
- Apply in-person at a DHHS local office. Find a local office at http://dhhs.ne.gov/Pages/Public-Assistance-Offices.aspx

SECTION IV

Please complete the application and provide the following documents for your household

- COPY OF MOST RECENT INCOME TAX RETURN – Federal & State (for all members living in your household) *OR*
- COPIES OF PREVIOUS THREE MONTHS PAY STUBS
- IF YOU RELY ON SOCIAL SECURITY FOR YOUR INCOME, PLEASE PROVIDE A COPY OF YOUR ANNUAL DISBURSEMENT LETTER

SRMC Financial Assistance Application

Household Information (for patient or guarantor if patient is a minor)

FULL NAME (Last, First, Middle Initial)

E-mail Address

Enter for everyone living in your home.

Household Members	Relationship to Guarantor	Gross Income	Child Support Paid	Child Support Received	Date of Birth	Disabled (Circle one)	Full-Time Student (Circle one)
						Y N	Y N
						Y N	Y N
						Y N	Y N
						Y N	Y N
						Y N	Y N
						Y N	Y N
						Y N	Y N

Personal Information

Applicant (Guarantor)	CO-APPLICANT (for Extended Financed options only)
FULL NAME (Last, First, Middle Initial)	FULL NAME (Last, First, Middle Initial)
PRESENT PHYSICAL ADDRESS / CITY / STATE / ZIP	PRESENT PHYSICAL ADDRESS / CITY / STATE / ZIP
☐ Married ☐ Unmarried ☐ Separated	☐ Married ☐ Unmarried ☐ Separated

Employment Information

NAME AND ADDRESS OF EMPLOYER — YEARS OR MONTHS WORKED	NAME AND ADDRESS OF EMPLOYER — YEARS OR MONTHS WORKED
PHONE NUMBER — JOB TITLE	PHONE NUMBER — JOB TITLE

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Income			
Applicant (Guarantor)		**CO-APPLICANT (for Extended Financed options only)**	
Gross Annual Income (Salary & Any Other)		Gross Annual Income (Salary & Any Other)	
Child Support/Alimony Received		Child Support/Alimony Received	
Child Support/ Alimony Paid		Child Support/ Alimony Paid	
TOTAL INCOME		**TOTAL INCOME**	

Investments					
Applicant (Guarantor)			**CO-APPLICANT (for Extended Financed options only)**		
Type	**Value**	**Amount of Debt Secured by Investment**	**Type**	**Value**	**Amount of Debt Secured by Investment**
Savings	$		Savings	$	
Retirement/ 401k	$		Retirement/ 401k	$	
Stocks	$		Stocks	$	
Bonds	$		Bonds	$	
Investment Property	$		Investment Property	$	
Other	$		Other	$	
TOTAL	$		**TOTAL**	$	

Property		Applicant	Co-Applicant
Real Estate Owned (Main Residence): Assessed Value: **$**____________________	Amount Owned Against Property: **$**____________________	☐	☐
Net worth of Business Owned: (Attach current financial statement) **$**________________________	Amount Owned Against Business: **$**____________________	☐	☐

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Property (continued)

Vehicles, Boats, Motorcycles, etc.

Year	Make/Model	Value	Amount Owned Against Property	Applicant	Co-Applicant
		$		☐	☐
		$		☐	☐
		$		☐	☐
		$		☐	☐
		$		☐	☐
		$		☐	☐
		$		☐	☐
	TOTAL	$			

Liabilities-Obligations

Applicant Co-Applicant

LIST ALL PERSONAL, TRUST PARTNERSHIPS OR CORPORATE DEBTS. INCLUDE RENT, DEBTS FOR 1ST AND 2ND LIEN LOANS (MORTGAGE OR TRUST DEED), AUTOS, APPLIANCES, FURNITURE, PERSONAL LOANS AND NOTES, CO-SIGNED NOTES, GARNISHMENTS/JUDGEMENTS, AND CREDIT CARD/CHARGE ACCOUNTS.

Owed to	Monthly Payment	Balance	Applicant	Co-Applicant
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
	$		☐	☐
TOTAL	$		☐	☐

I certify that the information provided is complete and true to the best of my ability. I also understand that if I make false statements on this application, any assistance I receive from the Sidney Regional Medical Center could be withheld and or reversed at a future date. I authorize Sidney Regional Medical Center to use any information contained in the application to verify my eligibility for assistance and to obtain records pertaining to eligibility from a financial institution as defined in Section 15-15-201(4), C.R.S. or from any insurance company.

Accepted:

Applicant:____ Date:_______________________

Co-Applicant:_____________________________________ Date:_______________________