CHILDREN'S HOSPITAL & MEDICAL CENTER
Application for Financial Assistance

Please note: This application will cover Children's Hospital, Children's Specialty Physicians, Children's Physicians, Children's Home Healthcare, and NPPI-Anesthesiology
Please provide the following information for everyone in the household.

Patient Name(s)			
Hospital, Physician or Home Healthcare Account #	**Balance Due**	**Hospital, Physician or Home Healthcare Account #**	**Balance Due**

Name of Person Completing Form		Relationship To Patient	
Mailing Address		Daytime Phone Number	
		Evening Phone Number	

# of Wage-Earners in Household		# of Dependents in Household		Total # in Household	
Total Monthly Gross Income (all wage-earners)	**(Please include alimony, child support, disability and unemployment in your income.)**				
Comments					

Please return the application and all required attachments via fax, e-mail or mail to:
Fax: 402-955-6850; E-mail: PFSSupport@childrensomaha.org
or mail to: Children's Hospital & Medical Center, Central Billing Office, P. O. Box 247036, Omaha, NE 68124-7036

- ✓ Completed Application for Financial Assistance form
- ✓ Most recent W-2 form or income tax return for all wage-earners
- ✓ One month of most recent pay stubs or document showing other source of income for all wage-earners / recipients.
- ✓ Notification from Health & Human Services stating patient is not eligible for Medicaid

Employee providing form to family		Date form given	
Date form must be returned (15 days)			

I certify that the above information is true and correct to the best of my knowledge and belief as of the date indicated below.

Signature of Person Completing Form	Date

For office use only	Percent and Dollar Amount of Financial Assistance Authorized	%	$
Authorized by:	Signature		Date