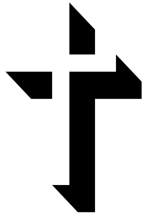

PATIENT ASSISTANCE APPLICATION

This application may be subject to a random audit of income and/or disease.

Mail application to The Catholic Foundation of Southern Nebraska, PO Box 80328, Lincoln NE 68501.

Please ensure you have included:

1. Completed Application
2. Financial Verification (Income Tax Return, Social Security Award Letter, or most recent Pay Stub)
3. Health Statement signed by your Physician

If your income status changes, you must immediately notify the We Care Endowment to determine whether or not you continue to qualify for assistance.

TODAY'S DATE ______________________

NEW APPLICANT? ☐ YES ☐ NO RENEWAL? ☐ YES ☐ NO

IF RENEWAL, WHEN DID YOU LAST APPLY? DATE ______________

WHO IS FILLING OUT THIS APPLICATION? ☐ PATIENT ☐ PERSON/PATIENT REPRESENTATIVE

IF REPRESENTATIVE, NAME ______________ RELATIONSHIP TO PATIENT ______________

PATIENT INFORMATION

PATIENT NAME ______________________ LAST NAME ______________________

GENDER ☐ MALE ☐ FEMALE BIRTH DATE ________ PREFERRED LANGUAGE ________

STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

STREET______________________ CITY ____________ STATE ___ ZIP________

COUNTY ____________ HOME PHONE (____) ____________ MOBILE (____) ____________

EMAIL ADDRESS ______________________

OKAY TO CONTACT PATIENT? ☐ YES ☐ NO IF YES, BEST TIME TO CONTACT____________

IF PATIENT IS A MINOR (UNDER 18), NAME OF PARENT OR GUARDIAN ______________________

ALTERNATE CONTACT ______________ RELATIONSHIP TO PATIENT ______________

PHONE (____) ____________

HOUSEHOLD FINANCIAL INFORMATION

SALARY $__________ DISABILITY $__________ UNEMPLOYMENT/WORK COMP $__________

SOCIAL SECURITY $__________ PENSION/RETIREMENT $__________

ALIMONY/CHILD SUPPORT $__________ OTHER INCOME $__________

HOUSEHOLD GROSS MONTHLY INCOME $__________ NUMBER LIVING IN HOUSEHOLD __________

PROVIDER INFORMATION

FACILITY/PRACTICE NAME __________ PHYSICIAN NAME __________

STREET __________ CITY __________ STATE _____ ZIP__________

PHONE (_____) __________ FAX (_____) __________

INSURANCE INFORMATION

☐ PRIVATE ☐ MEDICARE ☐ MEDICAID ☐ MILITARY ☐ UNINSURED

NUMBER OF MILES TRAVELED ROUND TRIP FOR EACH VISIT __________

PATIENT SIGNATURE __________ DATE __________

Once a determination has been made, you will be notified. The We Care Endowment may ask at anytime for further documentation to support a patient's eligibility, including after any grant has been extended. Any falsification of an application is fraudulent and subject to potential criminal penalties and civil damages.