Niobrara County Hospital District/Rawhide Rural Clinic offers Charity Care if you need help paying for your inpatient/outpatient hospital care or a clinic bill. Under this program, the hospital/clinic provides free or reduced-priced care based on your eligibility and income. You can get Charity Care even if you have insurance to assist in paying your copays and/or deductibles.

THIS APPLICATION MUST BE FILED WITHIN 10 DAYS UPON RECEIVING THE FORM

Date Given/Sent___________________________ **Date Received**_____________________

Personal Information

Applicant Name: ____

Mailing Address: ____

Telephone Number(s): Home: ________________________ Work: ______________________

List the people in your household below. Please list the dollar amount of the total monthly income that supports the household. Include money that is earned (paychecks, profits, interest, and savings) as well as income that is not earned (welfare, unemployment, child support, gifts and grants).

	Name	Birth Date	Relationship	Monthly Income
1				
2				
3				
4				
5				
6				
7				
8				

Health Insurance Information

Medical Insurance? Yes _____ No _____ If "Yes" print the name of insurance company

____

Policy Number: _____________________

Other Coverage? Yes_____ No ____ Please identify other coverage:

____

Medicare _______ Medicaid ______

Is the medical treatment because of an on-the-job injury or accident? Yes___ No___

Financial Information

Has your family had any seasonal or temporary increases or decreases in income? Or, do you expect your income to change in the next six months?

Yes___ No___ If yes, please describe: ____

____

Have you recently suffered severe financial hardship or personal loss (for example, other medical expenses, death of a loved one, loss of job or wages, loss of home, auto, or other property)?

Yes___ No___ If yes, please explain: ____

____

Do the documents that you are including with this application show your current financial situation correctly?

Yes___ No___ If no, why not____

____

If you are asking for financial assistance for services already provided by NCH or RRHC, please list the dates of services and what services you received:

____

____

____

Listing of Household Expenses

Type of Expense	Monthly Payment	Balance Due (if applicable)
Home Mortgage/Rent		
Car Payment #1		
Car Payment #2		
Credit Card #1		
Credit Card #2		
Credit Card #3		
Credit Card #4		
Homeowner's/Renter's Insurance		
Gas/Propane		
Electricity		
City (Water/Garbage)		
Home Phone		
Cell Phone		
Cable		
Internet Connection		
Health Insurance Premium		
Fuel (Gas/Diesel)		
Car Insurance		
Day Care		
School Lunch		
Groceries		
Miscellaneous (Please Specify)		
#1		
#2		
#3		
#4		
#5		
#6		
#7		
#8		

Listing of Medical Expenses

Type of Expense	Monthly Payment	Balance Due (if applicable)
HOSPITAL		
#1		
#2		
#3		
#4		

PHYSICIANS/CLINICS(list)		
#1		
#2		
#3		
#4		

MEDICATIONS (Patient's Portion)		
#1		
#2		
#3		
#4		
#5		
#6		
#7		
#8		

OTHER MEDICAL SERVICES (specify)		
#1		
#2		
#3		
#4		
#5		
#6		

I understand that the information I am giving will be verified by Niobrara County Hospital District/Rawhide Rural Health Clinic personal and reviewed by state and/or federal enforcement agencies and other as required. **Any falsification of information will lead to denial and/or revoking of Charity Care.**

I certify that the above information is true and accurate to the best of my knowledge

Applicant's Signature ____ Date ________________

INFORMATION
Be sure to include documents to support all income amounts you listed on page 1.

Required Documents:
- Pay stubs from employers, for all household members for the last 3 months.
- All bank statements including checking and saving, from all household members, for the last 3 months
- Investment accounts (CDs/stocks/bonds), if applicable.
- Letters approving or denying Medicaid, medical assistance and other benefits or
- Letters approving or denying unemployment compensation or
- Insurance Loss Claim forms or
- Disaster Recovery form.
- Written statements from employers or welfare agents, if requested.
- A W-2 withholding statement, if requested.
- Last year's income tax return, if requested.

Charity Care is considered secondary to ALL other financial resources available to the patient, which may include:
- Group or individual medical plans
- Worker's compensation
- Medicare
- Medicaid
- Medical assistance programs
- Other state, federal or military programs
- Third party liability situations (auto accidents and personal injuries)

Charity Care shall be limited to those residences within **Niobrara County**.

If you have any questions regarding this application please contact the *Business Office (307) 334-4000 Option 5*.

Mail this application with documentation to:

Niobrara County Hospital District
Business Office
P.O. Box 780
Lusk, WY 82225