PO Box 780
Lusk WY 82225
(307)334-4000 Ext. 240

Niobrara County Hospital District Charity Care Application

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

Date Given/Sent:______________________________ **Date Received:**____________________________

PERSONAL INFORMATION

Applicant Name:____

Mailing Address:____

Phone Numbers: Home/Cell:______________________ Work:______________________

List yourself and all dependents/people in home below. Please list the dollar amount of total monthly income that supports the home. List money that is earned (paychecks, profits, interest, and savings) as well as income that is not earned (welfare, unemployment, child support, gifts, and grants). Please supply your most recent tax return **or** 3 months of bank statements **and** a Medicaid denial letter. You can contact Medicaid at (855) 294-2127.

	NAME	BIRTHDATE	RELATIONSHIP	MONTHLY INCOME
1				
2				
3				
4				
5				
6				
7				

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8				

I UNDERSTAND THAT THE INFORMATION I AM GIVING WILL BE VERIFIED BY NCHD PERSONAL AND REVIEWED BY STATE AND/OR FEDERAL ENFORCEMENT AGENCIES AND OTHER AS REQUIRED. ANY FALSICIFICATION 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.

Applicants Signature: ____________________________ Date: ___________________

FOR OFFICE USE ONLY

Approve: ____

Approval for ___________%

Adjust off: _____________

Reason for recommendation: ____

____

Deny:____

Denial Reasoning: ____

____

Revenue Cycle Signature: ______________________________ DATE: ___________

Revenue Cycle Director Signature: _______________________ DATE: ___________

CEO Signature:____DATE:____________