Heart of America Medical Center
PO Box 1826 – Scottsbluff NE 69363-1826
Community Care Program Application

Date of Request: ____________________________

Instructions: Complete application and attach copies of at least one of the following:

- Tax returns and supporting schedules (previous year)
- Bank statements (most recent 3 months for all accounts
- Pay stubs (most recent 3 months)
- Social Security /Disability benefits

I, ____ hereby request that Heart of America Medical Center (HAMC) make a determination of my eligibility for community care program services at HAMC. I understand that the information which I submit will be subject to verification by HAMC, and if the information which I submit is determined to be false, it will result in a denial of caring program services.

Services not eligible for the community care program include, but are not limited to: non-medically necessary services, cosmetic services and long term care.

1. Name: ____
First Middle Last

Physical Address: ____
Number and Street City State Zip Code

Mailing Address ____
If different than physical address
Number and Street City State Zip Code

Social Security # ___________________________ Date of Birth: ___________________________

Marital Status: Single Married Widow Divorced

Telephone: _____________________________ Cell Phone: _____________________________

If student: School______________________________________ Full time _____ Part time _____

Occupation: ____________________ Date of unemployment, if applicable: __________________

Employer: ____ Phone: _________________________

Employer Mailing Address: ____
Number and Street City State Zip Code

2. Spouse Name: ____
First Middle Last

Social Security # _____________________________ Date of Birth: ____________________________

Telephone: _____________________________ Cell Phone: _________________________________

If student: School____ Full time _____ Part time _____

Occupation: _______________________ Date of unemployment, if applicable: __________________

Employer: ______________________________________ Phone: ____________________________

Employer Mailing Address: ____
Number and Street City State Zip Code

To be completed – facility personnel only
This document was received on by

3. **Dependents:** *Household dependents that are claimed on tax return.*
Dependents over 18 must show proof of disability and/or verification of income if providing towards support of household.

Name	Relationship	Date of Birth

If additional room is needed, please use the back of this page

4. **Income:** A) List total gross income for household below for the last 12 months;
B) You must provide a copy of your most recent Federal Income Tax Return (or complete a Form 4506-T to verify that you did not file Federal income Tax); or
C) You must provide us with verification of income for the last 3 months.

Self		**Spouse**	
Wage Income		Wage Income	
Farm or Self-Employment		Farm or Self-Employment	
Social Services (Food Stamps, AFDC, WIC, etc.). .		Social Services (Food Stamps, AFDC, WIC, etc.). .	
Social Security/Disability		Social Security/Disability	
Unemployment compensation . . .		Unemployment compensation . . .	
Worker's Compensation		Worker's Compensation	
Strike Benefits		Strike Benefits	
Alimony /Child Support.		Alimony /Child Support.	
Military Family Allotments		Military Family Allotments	
Pension		Pension	
Income from Dividends/Interest. .		Income from Dividends/Interest. .	
Rental Property		Rental Property	
Inheritance		Inheritance.	
Stocks/ Bonds		Stocks/ Bonds	
Other		Other	
Sub Total:		**Sub Total:**	

TOTAL: ______________________________

5. Health Insurance: Do you have any type of health insurance such as Blue Cross, Medicare, Medicaid, or commercial insurance? Yes No If yes, please specify below:
Insurance Name: ______________________ Policy # ____________ Group # ____________

Insurance Name: ______________________ Policy # ____________ Group # ____________

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In order to make a determination on your application, please provide me with the following:

____

Return requested documentation by: ___________________________________

I affirm that the information listed in this Request is true and correct to the best of my knowledge. I hereby authorize HAMC to investigate any information provided and I authorize the release of any information that HAMC deems necessary in making an eligibility determination.

__________________________________ __________________________________
Signature (person making request) Date