Capstone Behavioral Health, P.C.
Financial Assistance Application

Instructions

If you have not discussed your financial situation with Patient Financial Services, please do so prior to completing this form.

- The information you are providing on this application will help us assess your financial situation and determine your ability to pay for services provided at Capstone Behavioral Health and our affiliates.
- Note that until your financial statement has been reviewed and approved by our financial administrator, you will be financially responsible for your medical care.

In addition to the completed financial statement, you will be **required** to provide the following for **Proof of Income** with your application:

- Income tax returns, W-2 forms (previous 2 years)
- Copies of recent pay stubs for Responsible Party and Spouse (at least the last three)
- If Self Employed please provide the last 2 completed Federal Tax Returns with profit and loss reporting
- Proof of ineligibility for coverage that would otherwise pay for these service

  *****Your application cannot be considered without the above information*****

OMAHA
1941 South 42nd Street, Ste. 328, Omaha, NE 68105
Phone: 402-614-8444 Fax: 402-614-8443

FREMONT
230 E. 22nd St. Ste. 4, Fremont, NE 68025
Phone: 402-727-1592 Fax: 402-727-4288

To be filled out by Responsible Party:

Patient Name		Date of Birth	
Responsible Party	Social Security Number	Home Phone	
Address	City	State	Zip Code
Employer	FT/PT Work Number	Month Gross Income	
Spouse's Name	Social Security Number	Monthly Gross Income	
Employer	FT/PT Work Number		
Responsible Party's Other Income	Spouse's Other Income		
Family Size	Annual Gross Household Income	Age(s) of Dependent Children	
Name(s) of Children			

PROOF OF INCOME REQUIRED:

- Income tax returns, W-2 forms (previous 2 years)
- Copies of recent pay stubs for Responsible Party and Spouse (at least the last three)
- If Self Employed please provide the last 2 completed Federal Tax Returns with profit and loss reporting
- Proof of ineligibility for coverage that would otherwise pay for these service (whether through employer-based coverage, commercial insurance, government sponsored coverage or third-party liability coverage)

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Other Income Source Documentation

Social Security (earnings record)	VA Assistance	Railroad Retirement	Child Support	Disability	Life Insurance
Pension	Alimony	Unemployment	Workman's Comp	Public Assistance	Other: Please List:_____

Household Assets

Cash on hand (include checking) $_____
Savings $_____
Stocks/Bonds/Retirement funds $_____
Vehicles
Year_____ Make_____ $_____ (value)
Year_____ Make_____ $_____ (value)
Home: Estimated Value (if own) $_____
Other Assets_____ $_____
Other Assets_____ $_____
Total Assets: $_____
Net Worth (Assets-Liabilities) $_____

Liabilities and Net Worth

Bank Loans $_____
Total Credit Cards $_____
Home Mortgage
__Rent __Own
Other Liabilities _____ $_____
Other Liabilities _____ $_____
Other Liabilities _____ $_____
Total Liabilities: $_____

Fixed Monthly Expenses

House Payment/Rent $_____
Utilities $_____
Telephone $_____
Cable TV $_____
Medical Bills $_____
Prescription Drugs $_____
Insurance $_____
Groceries $_____
Child Care $_____ Child Support $_____
Other $_____ $_____
Total Monthly Expenses $_____

I hereby acknowledge that the information given to Capstone Behavioral Health is true and correct to the best of my knowledge. I authorize Capstone Behavioral Health to verify any or all of the information given and to obtain a consumer credit report, to be obtained as deemed necessary.

Patient/Guarantor's Signature:	Date:

*****You may be required to complete a new form for each date of service*****

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If you have any questions regarding this form, please contact Nikki Conner at (402) 614-8444, Monday through Thursday at 8:30a.m. – 4:00p.m. Messages can be left after hours.

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