Dialysis Center of Lincoln and Home Dialysis of Lincoln
Financial Assistance Application
(Please Complete All 4 Pages)

When complete, fax to Billing Department at 402-489-7366 or mail to DCL, ATTN: Billing Department, 7910 'O' Street, Lincoln, NE 68510. Make sure to include all supporting documents. If you have any questions, please call the Billing Department at 402-489-5339.

Date of Application: _____ Account Number: _____

Patient Information

Name: _____ Street Address: _____

City, State, Zip: _____ Phone: _____

Social Security Number: _____ Birthdate: _____

Employment Status (circle) Disabled Employed Retired Unemployed Other _____

Marital Status (circle) Single Married Separated Divorced Other_____

Preferred Language: _____

Responsible Party Information

___ Self (leave blank)

___ Other (please complete below)

Name: _____ Street Address: _____

City, State, Zip: _____ Phone: _____

Social Security Number: _____ Birthdate: _____

Patient Name: _____

Household Information

Please list all family members living in your household during the past year, including you. "Family" includes two or more people related by birth, marriage, or adoption who live together. If a patient can claim someone as a dependent on his or her income tax return, that person would be a member of the Patient's family for purposes of this Application.

Name	Age	Relationship	Employer/ Income Source	Dependent Y/N

Total Number of Family Members: _____

Financial Information

- Complete financial information is required on all Family Members aged 18 and over.
- Relevant documentation should be provided for each income source.
- Submit a copy of your most recent Federal Income Tax return.
- If applicable, submit most recent 3 months of paystubs.
- If applicable, submit a copy of the most recent Social Security Administration (SSA) benefit statement.
- If applicable, include any retirement or pension benefit statement(s).
- If future income will change significantly, include a one-page statement why on page 4 and provide documentation.

Household Assets

Checking Account Balance: _____

Savings Account Balance: _____

Home Assessed Value: _____

Stocks and Bonds Value: _____

Patient Name: _____

Monthly Household Income

Patient Gross Monthly Income: _____

Spouse Gross Monthly Income: _____

Additional Household Gross Monthly Income: _____ Source: _____

Child Support: _____

Retirement Income: _____

SSI/SSD Benefits: _____

Veterans' Benefits: _____

Other Income: _____ Source: _____

Total Monthly Income: _____

If monthly income is left blank, specify reason:

_____

_____

____ Check if you did not file an Income Tax Return. Briefly explain why.

_____

_____

___ Check if you are claimed as a dependent on anyone else's tax return.

If yes, whose? _____

Patient Name: _____

Use this page to indicate if future income will change significantly (due to death of a family member, disability status, inability to work, etc.) or if other areas of the application require greater explanation. Documentation is required to substantiate income explanations. For example, a letter from a past employer, a letter from your doctor stating your inability to work as a result of your illness, etc.

I hereby acknowledge that the information given to the Dialysis Center of Lincoln is true and correct to the best of my knowledge. I hereby authorize the Dialysis Center of Lincoln to verify any or all information given, and I also authorize a consumer credit report may be obtained if necessary.

Patient/Patient Representative Signature: _____ Date: _____

Responsible Party Signature (if other than patient): _____ Date: _____

Spouse Signature: _____ Date: _____

Patient Name: _____

For DCL/HDL Office Use Only	
Determination Date	
Number in Household	
FPL	
Annual Income	
Determination	
Financial Assistance Discount	
Additional Notes:	