Patient/ Guarantor Account # (s):	Patient Name:		
Address:	City:	State:	Zip:
Contact Phone Number:	Date of Birth:	SSN:	
Responsible Party/Parent/Guardian Name:	Spouse/Other Parent Name:		
Names and Ages of Dependent Children:			
Income Information			
Responsible Party's Employer:	Hire Date:	□ Full Time □ Part Time	
Monthly gross income: $	Monthly net (take-home pay): $	Annual gross income: $	
Spouse/Other Parent Employer:	Hire Date:	□ Full Time □ Part Time	
Monthly gross income: $	Monthly net (take-home pay): $	Annual gross income: $	
Child Support: $	Unemployment: Monthly: $ Date Started:	Pension: $	Alimony: $
Disability\SSI: Monthly: $	HRA/HSA Balance: $	Other Income:	
Total Household Income: $	**Total Monthly gross income: $**	**Total Monthly net (take-home pay):$**	
Additional Information:			

Fixed Monthly Expenses/Assets								
Payment To	For	Amount Owed	Monthly Pmt	Payment To	For	Amount Owed	Monthly Pmt	Other Assets:
Medical		$	$	Child Support/Alimony		$	$	Checking $
Medical		$	$	School Tuition		$	$	Name of Bank
Insurance - Auto		$	$	Phone/Cable/Internet		$	$	Savings $
Housing – Mortgage/Rent		$	$	Food/Groceries		N/A	$	Name of Bank
Automobile make/model		$	$	Medications		N/A	$	Stocks/Bonds/Retirement Funds: $
Automobile make/model		$	$	Utilities		$	$	Other Assets:
Loans - Sum of All		$	$	Gas/Auto		N/A	$	
Child care		$	$	Other Expenses		$	$	
Have you applied for state or county Medical assistance: □ Yes □ No Date applied:								
If your monthly expenses are more than your income, please explain how you pay your monthly debt:								

PROOF OF INCOME: In order to process your application, a copy of all of the following information must be submitted by mail, email, fax or drop off:

- Copy of current bank statements
- Copy of Federal Tax Return (current year) including all schedules
- Patient may be required to file for Medicaid assistance, if denied, must provide the denial letter.
- Proof of fulltime student status
- Copy proof of all income for household including: Last two pay stubs, unemployment determination, child support, pensions, and or SSI

I hereby acknowledge that the information given to Boys Town National Research Hospital is true and correct to the best of my knowledge. I authorize Boys Town National Research Hospital to verify any or all information given and to obtain a consumer credit report as deemed necessary.

Patient\Guarantor's Signature:_____ Date: _____

Mail completed form and attachments to: **Boys Town National Research Hospital, Attention: Financial Counselor**
555 N 30th Street, Omaha, NE 68131 or email to ptfinancialservices@boystown.org or fax to 531-355-8103

Last Updated 08/31/2022

For any questions, please contact a Financial Counselor at 531-355-8195 or email ptfinancialservices@boystown.org