MADONNA REHABILITATION HOSPITAL
5401 SOUTH STREET
Lincoln, NE 68506

PERSONAL FINANCIAL STATEMENT

RESPONSIBLE PARTY

Name: _____ Marital Status: _____

Present Address: _____
(Street) (City, state, zip) (Phone)

Years at present address: _____ Own_____ Rent_____

Employer:_____
(Name, address, phone number)

Position/Title: _____ Years employed here:_____

Dependents: List names and ages

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Spouse's Name:_____ Age: _____

Present Address: _____
(Street) (City, state, zip)

Employer:_____
(Name, address, phone number)

Position/Title: _____ Years employed here:_____

These questions apply to both responsible party and spouse. Answer "yes" or "no". If "yes" is answered to any question, please provide and attach an explanation to this form.

		You	Spouse
1.	Are there any outstanding judgments against you?	_____	_____
2.	Have you declared bankruptcy within past 7 years?	_____	_____
3.	Are you a party to a lawsuit?	_____	_____
		Yes	No
4.	Are you a U.S. citizen?	_____	_____
5.	Are you a Nebraska resident?	_____	_____

MONTHLY INCOME (for each wage earner living in household, if age of majority)

	Responsible Party	Spouse	Other	Total
*Net Wages:	$_____	$_____	$_____	$_____
*Social Security:	$_____	$_____	$_____	$_____
Unemployment:	$_____	$_____	$_____	$_____
Disability/SSI:	$_____	$_____	$_____	$_____
Public Assistance:	$_____	$_____	$_____	$_____
Alimony:	$_____	$_____	$_____	$_____
Child Support:	$_____	$_____	$_____	$_____
Pensions:	$_____	$_____	$_____	$_____
*Dividends/Interest:	$_____	$_____	$_____	$_____
*Rental Income:	$_____	$_____	$_____	$_____
*Worker's Compensation:	$_____	$_____	$_____	$_____
Total:				**$**_____

*Verification must include prior year tax return AND two of the following: Current pay stubs, written verification of wages from employer, unemployment letter, social security check, bank statement disability check, letter of eligibility for cash assistance.

I affirm that the above information is true and correct to the best of my knowledge.

_____ _____

Date Responsible Party's Signature

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OFFICE USE ONLY:

Estimated plan of care/funds requested: Inpatient $_____Outpatient/Rehab Day $_____ Physician $_____.

_____

_____

YES	NO		YES	NO	
____	____	United States Citizen	____	____	Resident of Nebraska
____	____	Financial Criteria Met ____Income verification provided ____Poverty guideline met ____Other possible payers verified	____	____	Program Criteria Met ____Physician orders received ____Patient has rehabilitation potential
____	____	Estimate of projected charges completed ____Cost of therapy ____Cost of other services (lodging, transportation, meals, etc.)	____	____	Case Management and Patient Accounts have agreed on recommendation

_____ _____

Case Manager Patient Accounts Representative

Approved funding: Inpatient $ _____ Outpatient/Rehab Day $_____ Physician $_____.

Total Funding: _____Approved by: (VP of Rehab, CEO, COO)_____Date: _____