Personal Financial Statement

(Please Complete All 4 Pages)

When complete, fax to Heather at 402-489-5339 or mail to DCL, ATTN: Heather, 7910 'O' Street, Lincoln, NE 68510. Make sure to include all supporting documents, such as most recent tax return, Social Security benefit letter and retirement statements if applicable. If you have any questions, please call Heather 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 the home during the past year:

Name	Age	Relationship	Dependent (yes/no)

Total Number of Dependents: _____________

Financial Information

- Complete financial information is required on all household members
- Submit a copy of the most recent Federal Income Tax return showing the Adjusted Gross Income. If you did not file an income tax return, briefly explain why.
  ____
- 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: __________________

O St.
402.489.5339
7910 O St.
Lincoln, NE 68510

Northwest
402.438.7330
3211 Salt Creek Cir.
Lincoln, NE 68504

Southwest
402.742.8500
5355 S. 16th St.
Lincoln, NE 68512

Columbus
402.563.2139
2452 39th Ave.
Columbus, NE 68601

Home Dialysis
402.742.8500
5355 S. 16th St.
Lincoln, NE 68512

Patient Name: ___________________________________

Monthly Household Income
Patient Take Home Pay: _______________________

Spouse Take Home Pay: _______________________

Additional Household Income: ____________________ Source: __________________________________

Child Support: ____________________________

SNAP Benefits: ____________________________

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 and Income Tax Return. Briefly explain why.
____
____

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

If yes, who? _______________________

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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 for 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: ___________

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Spouse Signature: ____ Date: __________

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