Audubon County Memorial Hospital
515 Pacific Avenue
Audubon, IA 50025
Ph. 712-563-2611

Dear Applicant:
You may be able to get financial help from Audubon County Memorial Hospital.
To get financial help, you must have tried to get, and been refused, all other sources of payment including insurance, public assistance, or a lawsuit.
To find out if you or your household qualifies, you must give us proof of your income. Please fill out the attached application and sign it. Then, please send us that application and a COPY of each of the following for your household:

__ 1. Complete copy of your most recent Federal Income Tax Return and all schedules.
__ 2. Last year's W-2 forms
__ 3. Copies of the three (3) most recent, consecutive paycheck stubs or a statement from the employer
__ 4. Copies of the three (3) most recent bank statements (e.g., savings, checking, money market, IRA, 401K, etc.)
__ 5. Copies of unemployment or disability compensation benefits statements
__ 6. Copies of pension benefits stubs
__ 7. Copies of social security income (yearly benefits statements, copy of check or direct deposit)
__ 8. Copy of Food Stamp allocation
__ 9. Copies of government assistance notices (including Department of Health & Human Services). If you have not filed for Medicaid, you will need to do so by contacting the Department of Health & Human Services.

Please use this checklist to be sure we have all the information we need to quickly and correctly process your application. We may ask you for additional information about your credit evaluation and income tax return. The information you provide is confidential.
You will continue to be financially responsible for any services you receive until we have learned whether you qualify for help.
If you have not heard from us in 30 days after returning your application, or you need help in understanding it, please call :

Melinda Alt, CFO at 712-563-5305

Financial Assistance Application

1. Patient's Information:

_____

Last Name *First Name* *Middle Initial* *Social Security Number* *Date of Birth*

_____

Street Address *City* *State* *Zip code*

_____ *check one:* _ Single _ Married

Home Phone Number *Work Phone Number* _ Separated _ Divorced _ Widowed

2. Person Responsible for Paying the Bill:

_____

Last Name *First Name* *Middle Initial* *Relationship to Patient* *Social Security Number*

3. **Please indicate ALL people living in the household, including applicant: Use additional sheet of paper if needed

NAME *RELATIONSHIP TO PATIENT* *DATE OF BIRTH* *SOC. SECURITY #* *DOCTOR'S NAME*

1_____

2_____

3_____

4_____

5_____

4. Has anyone in your household applied for Medicaid coverage or affordable coverage under the Patient Protection and Affordable Care Act @ healthcare.gov? ____ Yes ____No

5. Have you recently filed a workers compensation claim or motor vehicle accident claim? ___Yes ___No

6. Is anyone in your household eligible for Social Security benefits? ___ Yes ___No

7. Is anyone in your household covered by health insurance or a health savings account (HSA)? ___Yes ___No

8. Does anyone else claim you on their income tax return? ___Yes ___No

9. HOUSEHOLD INFORMATION **PERSON 1** **PERSON 2** **PERSON 3**

***NAME of each household member:** _____ _____ _____

NAME of employer: _____ _____ _____

Monthly Income From

Employment $ _____ $ _____ $_____

Self-Employment $ _____ $ _____ $_____

Investment Accounts $ _____ $ _____ $_____

Real Estate rentals $ _____ $ _____ $_____

Unemployment*:*
since (_____/____/_____) $ _____ $ _____ $_____

Retirement $ _____ $ _____ $_____

Social Security $ _____ $ _____ $_____

Alimony/Child Support: $ _____ $ _____ $_____

Public Assistance, Food Stamps $ _____ $ _____ $_____

Other Income $ _____ $ _____ $_____

Savings and Investments:

Checking Account $ _____ $ _____ $_____

Savings & CD Account $ _____ $ _____ $_____

IRA, 403B, 401K: $ _____ $ _____ $_____

Specify_____
Other savings and investments $ _____ $ _____ $_____

Specify _____
Other
Value of Automobile: $ _____ $ _____ $_____

What is the Year, Make, Model

Value of Recreation Vehicle: $ _____ $ _____ $_____

What is the Year, Make, Model

10. HOUSEHOLD EXPENSES

Monthly Rent Payment: $ _____ or Mortgage Payment: $ _____ Mortgage Loan Balance $ _____

Property Tax Amount Not Included in Payment Amount Above: $ _____
Value of Home: $ _____
Do You Own Property Other Than Primary Residence? ____Yes _____ No If Yes, What is the Value? $ _____
Monthly Loan Payment: $ _____ Paid to: _____
For: _____
Monthly Loan Payment: $ _____ Paid to: _____
For: _____

Medicare Part D Deducted from social security check? ___Yes ___No

Utilities $ _____ Insurance (Auto/Life/Property) $ _____ Other: _____ $ _____

Alimony/Child Support $ _____ Health Insurance $ _____ Other: _____ $ _____

Child Care $ _____ Healthcare Bills $ _____ Other: _____ $ _____

Living (gas, food, clothes) $ _____ Medications $ _____ Other: _____ $ _____

11. ASSIGNMENT OF RIGHTS *Read Carefully*

By signing below I authorize Audubon County Memorial Hospital to request my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.

By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete or false information that I provide or someone else provides for me could cancel my application for financial assistance.

All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance. I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment. If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

_____ _____

Applicant Signature Date Co-applicant Signature Date