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 unemployment or disability compensation benefits statements
__ 5. Copies of pension benefits stubs
__ 6. Copies of social security income (yearly benefits statements, copy of check or direct deposit)
__ 7. Copy of Food Stamp allocation
__ 8. Copies of government assistance notices (including 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. The information you provide is confidential.
Items noted with "**" are optional.
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*

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* *DOCTOR'S NAME*

1_____

2_____

3_____

4_____

5_____

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	$ _____	$ _____	$_____

11. ASSIGNMENT OF RIGHTS *Read Carefully*

By signing below 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.

_____ _____

Applicant Signature Date Co-applicant Signature Date