



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

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