



Henry County Health Center

APPLICATION FOR FINANCIAL ASSISTANCE

This completed application for financial assistance must be completed and returned with proof of income. This includes a copy of your last year's income tax form 1040 or W-2 form and three months of paycheck stubs with year to date income. Application must be made through Department of Human Services for Medicaid and The Iowa Care Program. If approved, please supply copies of those cards or if denied, copies of a letter stating you were not eligible for either program. Please complete this application form by filling in all applicable blanks. We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief

PATIENT NAME: _____ BIRTHDATE: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

TYPE AND AMOUNT OF ASSISTANCE REQUESTED: _____

PLEASE LIST ANY COVERAGE BY INSURANCE, MEDICARE, MEDICAID, OR OTHER PROGRAMS:

POLICY NUMBER: _____ SUBSCRIBERS NAME: _____

GUARANTOR INFORMATION
(Person financially responsible and relationship to patient)

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME PHONE: _____

_____ WORK PHONE: _____

SPOUSE: _____ WORK PHONE: _____

Please complete and return to:
Henry County Health Center
Attention: Patient Accounts
407 South White Street
Mt. Pleasant, IA 52641

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INCOME

Does anyone in your family receive any of the following income? Circle yes or no for each item.
 Complete the information line on items circled yes.

Source of income	Circle one	Amount	How often is Income Received?	Name or Names of Person(s) Receiving
AFDC-Aid for Dependent Children	Yes No			
Self Employment	Yes No			
Employment	Yes No			
Student Loan or Grant Training Allowance JTPA	Yes No			
Job Insurance Benefits Worker's Compensation	Yes No			
Social Security Railroad Retirement				
Supplemental Security Income (SSI)	Yes No			
Veterans Benefits	Yes No			
Child Support / Alimony	Yes No			
Military Dependency Allotment or allowance	Yes No			
Disability Insurance Payments	Yes No			
IPERS, Civil Service	Yes No			
Other Pension or Compensation	Yes No			
Money from other Persons, Gifts, Loan	Yes No			
Money from Interest, Dividends	Yes No			
Room and / or Board	Yes No			
Commissions or Other Lump Sum Payments	Yes No			
Other (Explain)	Yes No			
HSA Account	Yes No			

EMPLOYMENT HISTORY (Most Recent)

Person	Employer	Kind of Work	Date Began	Date Ended	Monthly Wages	Reason for Discontinuing

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RESOURCES

Does anyone in your home have any of the following resources? Circle yes or no for each item.
 Complete the information line for items circled yes.

		Amount	Location	Name(s) or Person(s)
Cash on Hand	Yes No			
Checking Account	Yes No			
Savings Account	Yes No			
Stocks / Bonds	Yes No			
Time Certificates	Yes No			
Burial Contract / Plot	Yes No			
Conservatorship / Trust	Yes No			
Safety Deposit Box	Yes No			

		Make / Year	Market Value	Amount Owed	Monthly Payment
Automobile(s)	Yes No				
Truck(s) / Motorcycles	Yes No				
Snowmobiles / Boats	Yes No				
Mobile Home / Camper	Yes No				
Farm Equipment	Yes No				
Other (Specify)	Yes No				

Do you own, or are you buying the home in which you are living? _____ Yes _____ No
 Market Value \$_____ Amount Owed \$_____ Monthly Payment \$_____

If you rent, monthly rental payment is \$_____.

Does anyone in your home own or is buying real estate other than your homestead (lots, farmland, rental, etc)?
 _____ Yes _____ No If "yes", please list separately:

	Market Value	Amount Owed	Monthly Payment

Has anyone in your home received anything with cash value in the last two years (i.e., gifts, inheritance, winnings, settlements, etc.)? _____ Yes _____ No If yes, list item and value: _____

MISCELLANEOUS INFORMATION

Does anyone in your home have any of the following: Life Insurance or Burial Benefits _____ Yes _____ No
 If "Yes", list insurance company, address, policy # and coverage: _____

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MISCELLANEOUS INFORMATION (Continued)

Have you, your spouse, or dependent applied for all the benefits for which you might be eligible? _____ Yes _____ No

Are you an American citizen? _____ Yes _____ No

If "no", are you a legal alien? _____ Yes _____ No

Do you, your spouse, or dependent children have a serious disability? _____ Yes _____ No

If "yes", please explain and attach a statement from doctor regarding your inability to work: _____

List all of the people living in your household:

Name	Relationship	Social Security #	Birth date

Total gross family income for the prior three months: \$ _____

Gross family income from most recent tax returns: \$ _____

If unemployed, how long? _____

Future income expectations: _____

Have you applied for assistance through County relief efforts? _____ Yes _____ No If "yes", date _____

Have you applied for assistance through DHS? _____ Yes _____ No If "yes", date _____

OTHER EXPENSES / OUTSTANDING BILLS

Insurance:

	Monthly Payment	Balance Due
Car	\$ _____	\$ _____
Life	\$ _____	\$ _____
Home	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____

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OTHER EXPENSES / OUTSTANDING BILLS (Continued)

Loans:

Bank /Financial Co:

_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____
Other: _____	\$ _____	\$ _____

Credit Cards:

_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Bills:

Hospital / Doctors	\$ _____	\$ _____
Utilities (water, gas, electric)	\$ _____	\$ _____
Telephone	\$ _____	\$ _____
Others (food, cable TV, property taxes, Babysitter, court ordered payment / child support, etc.)	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Other circumstances that you feel should be considered during the review of this application: _____

CERTIFICATION

I certify that all the information provided is true and correct and understand that a misrepresentation of the above statements may result in denial of financial assistance or possible reversal of financial assistance of previous account(s).

Signature of Applicant

Date