APPLICATION FOR FINANCIAL ASSISTANCE

Henry County Health Center
407 S. White Street
Attn: PFS
Mt. Pleasant, IA 52641

The undersigned applicant requests that Henry County Health Center provide financial assistance and that a determination be made as to the applicant's eligibility for financial assistance on the basis of the following information:

Patient Name: _____Date of Birth_____

Date(s) of Service: _____

Is patient covered by: (Y or N) ____ Insurance ____ Medicare ____ Title 19
____ Government Programs, Other (Specify) _____

Person financially responsible for bill (guarantor):
Name: _____ Phone (cell and home): _____

Address: _____
Street City State Zip
Employer: _____

Names of persons in family (spouse and/or all members claimed on income taxes)
_____
_____
_____

FINANCIAL INFORMATION:

List all major and secondary sources of *****gross income for prior 12 month period (all family members)

Employer: _____ $ _____

Secondary Sources - Pensions, Social Security, Child Support, Public Assistance, Workers Comp/other

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____

Total gross family income for prior 12 months.....$ _____

IF none, how are your housing, food, and transportation expenses met? _____
_____

*****Proof of income (W-2 or pay stubs from last three months, tax returns, and verification of wage from employer or from public assistance agencies) must be furnished.

**Provide documentation from DHS proving eligibility or denial of their financial assistant programs. If you are eligible, you will be required to apply with DHS first.

Last 3 months total gross family income..... $ _____

Unemployed? Yes _____ No _____ If yes, for how long? _____

Future income expectations? _____
_____

Assets (required for hospital-based services/optional for clinic services)	Total Value
Checking and Savings.....	$ _____
Stocks, bonds, time certificates.....	$ _____
Cars.....	$ _____
Leisure vehicles - campers, boat, etc.....	$ _____
Home value……..	$_____
Health Savings Account……..	$_____
Property - lots, farmland, rental.....	$ _____
TOTAL ASSETS.....	$ _____

Expenses (required for hospital-based services/optional for clinic services)

	Balance Due	Monthly Payment
House payment/Rent.....	$_____	$_____
Utilities - Lights, Phone, Water, Cable.....	$ _____	$ _____
Insurance - Car, Life, Health, House.....	$ _____	$ _____
Loans - Vehicles, Education, Etc.....	$ _____	$ _____
Credit Card Payments.....	$ _____	$ _____
Medical Bills - Dentist, Doctor, Pharmacy.....	$ _____	$ _____
Others.....	$ _____	$ _____
TOTAL EXPENSES.....	$ _____	$ _____

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

I certify that the above information is true and correct and understand that a misrepresentation of the above statements may result in denial of financial assistance.

_____ _____
Signature of Applicant Date

If you have any questions please call our Patient Financial Services at (319) 385-6140.

DEFINITIONS:
INCOME refers to total cash receipts before taxes from all sources. It includes money, wages, and salaries before any deductions, but does not include food or rent in lieu of wages. It also includes net income from self-employment from farm and business. It includes regular payments from public assistance, social security, unemployment, and worker's compensation, strike benefits, training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the same household; government employee pensions, private pensions, and regular insurance or annuity payments; and income from dividends, grants, interest, rents, royalties, or income from estates and trusts. Please Note: Radiologist fees (for reading x-rays), reference laboratory testing, drugs and some physician charges are not covered under this application and will be your responsibility.