APPLICATION FOR FINANCIAL ASSISTANCE

In recognition of Community Memorial Hospital's policy to provide quality health care to all persons regardless of their financial status, the hospital's financial assistance program provides assistance to those in need in a fair, non-discriminatory manner.

Financial Assistance Instructions

1.) All efforts from "other" assistance must first be exhausted.

2.) To be eligible for financial assistance each applicant must first meet the minimum gross income requirements.
Gross income qualification is based upon the Community Service Administration
Income Poverty Guidelines. If applicant meets gross income eligibility requirements, they must then meet cash
Asset requirements to qualify and receive financial assistance.

3.) The Hospital reserves the right to request verification of income. Refusal of an applicant to provide requested
information will result in denial of financial assistance. Please follow instructions regarding income verification on enclosed instruction sheet.

4.) Financial assistance determination is considered on a per account basis.

5.) Financial Assistance will not be granted in any of the following circumstances:

A. Fraudulent information at time of registration or on the financial assistance application. (i.e.: Name,
Address, Employment, income, Assets, etc.)

B. Services <u>not meeting Medical Necessity</u> guidelines for hospitalization.

C. Any portion of an account balance payable or expected to be payable by any third party.

6.) Financial Assistance Applicants will be responsible for paying any remaining balance in accordance with
Hospital payment policies and/or agreements. Failure to do so subject any remaining balance to hospital
Collection procedures.

INSTRUCTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1. Reason for Application: Please write brief explanation of your current situation and why applying for financial assistance

2. Complete all areas of application.

3. Date and sign the application.

4. Please submit the following information with your application. *Failure to provide requested information, or separate explanation as to why the information was not submitted, will result in an incomplete application.* Financial assistance can not be provided without requested information.

   Submit the following items as applicable (If not applicable, please explain why):

☐ Paycheck/unemployment check stubs (last 3 months).

☐ Most recent Federal and State Tax Returns (including all supporting documents).

☐ Most recent certified financial statement. (Business owners/Self employed)

☐ Checking and Savings Account Statements (past 3 months).

☐ Statement of monthly benefit from Social Security.

☐ **Other**:

The application will not be processed unless the application is completely filled out and accompanied by the requested income verification.

****IF YOU HAVE ANY QUESTIONS, PLEASE CALL (563) 578-2158.****

Community Memorial Hospital Financial Assistance Application

Reason for Application

_____
_____
_____
_____
_____

Patient Name

Name _____ Telephone_____
(Last) (First) (MI)
Address_____ Birthday_____ Age _____
(Street)
_____ Soc.Sec.No. _____ Marital Status _____
(City) (State) (Zip)

Responsible Party Information (if different from above)

PERSONAL

Name _____
(Last) (First) (MI)
Address _____
(Street)
_____
(City) (State) (Zip)
Telephone _____
Birthday _____ Age _____
Soc.Sec.No. _____ Marital Status _____

EMPLOYMENT

Employer _____
Address _____
(Street)
_____
(City) (State) (Zip)
Telephone _____
Job Title _____
Job Status: PT/FT Avg weekly hrs _____

Spouse of Responsible Party Information (if different from above)

PERSONAL

Name _____
(Last) (First) (MI)
Address _____
(Street)
_____
(City) (State) (Zip)
Telephone _____
Birthday _____ Age _____
Soc.Sec.No. _____ Marital Status _____

EMPLOYMENT

Employer _____
Address _____
(Street)
_____
(City) (State) (Zip)
Telephone _____
Job Title _____
Job Status: PT/FT Avg weekly hrs _____

Other Information

List All Other Person(s) Living in the Household

Name Relationship Age
_____
_____
_____
_____
_____
_____
_____

Second Employer for Responsible Party and/or Spouse

Employer _____
Address _____
(Street)
_____
(City) (State) (Zip)

Telephone _____
Job Title _____
Job Status: PT/FT Avg weekly hrs _____

Other Source of Income

Source of Income	Check One	Amount Received	How Often Received	Name of Recipient
Employment Inc. Applicant	___Yes ___No			
Employment Inc. Spouse	___Yes ___No			
Social Security	___Yes ___No			
Child Support/Alimony	___Yes ___No			
Pension/Compensation	___Yes ___No			
Interest/Dividend	___Yes ___No			
Other (Explain)	___Yes ___No			

Assets

Item	Amount	Description/Account Numbers
Checking Account		
Savings Account		
Stocks/Bonds/CD's		
Time Certificates		
Motor Vehicles		
Primary Residence		
Other Property		
Total Assets (Lines 1-8)		

Liabilities

Item	Total Amount Owed	Monthly Payments	Description/Account Numbers
Home Mortgage			
Rent (Monthly Pmts)			
Utilities (Elec,Water,etc.)			
Medical Obligations			
Medical Obligations			
Prescriptions			
Bank Loans (Auto)			
Bank Loans (Personal, etc)			
Insurance (Auto, Med, etc)			
Credit Card Debt			
Total Liabilities (Lines 1-10)			

CONSENT FOR RELEASE OF INFORMATION

I certify all information is true and correct to the best of my knowledge. I understand that provision of any false or misleading claims, statements, documents or concealment of a material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Community Memorial Hospital and its representatives to investigate the information contained herein.

I also agree to notify Community Memorial Hospital of any changes in my financial position that would impact this determination.

Preparer's Signature Date

Spouse's Signature Date