VETERANS MEMORIAL HOSPITAL

Financial Assistance Application

40 1st Street SE, Waukon, IA 52172 Phone: 563-568-3411 website: www.veteransmemorialhospital.com

PLEASE CHECK ALL BOXES BELOW THAT APPLY AND PROVIDE SUPPORTING DOCUMENTATION	
☐ Medicaid Eligible, but not for date of service or for non-covered service	☐ Deceased with no estate
☐ Homeless – Explain:	☐ Incarceration in penal institution

Medical Assistance Eligibility *(Please provide documentation of current status)*	
☐ I have applied for Medical Assistance	☐ Applied for – but not eligible
☐ I will be applying for Medical Assistance for effective date of :	☐ Other:

PLEASE ATTACH COPIES OF THE BELOW REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION	
☐ Investment Statements (Ex – Bank CD's, Investment earnings)	☐ Property tax statements
☐ Pay stubs for all sources of income reported from employers for 1 month	☐ Unemployment Earnings for 1 month
☐ Social security benefits	☐ Checking and savings bank statements
☐ Other – Describe:	☐ Mortgage balance statement
Filed Federal Income taxes: ☐ Yes – Please provide the most recently filed Federal Income tax return and supporting schedules ☐ No – Please explain:	

PATIENT OR RESPONSIBLE PARTY			
Please check applicable status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated			
Name (*first, middle, last*):		Social Security Number:	
Address:		Birth Date:	
City:	State:	Zip Code:	County:
Phone Number:		Household Size (Applicant, Spouse, Dependents)	
Employment Status: ☐ Full time ☐ Part-time ☐ Self-Employed ☐ Unemployed ☐ Retired			
Employer Name and address:			
Length of employment with current employer:		How often paid (Ex – Weekly/Bi-Monthly)	
Are you claimed on another tax return: ☐ Yes - Please explain _____ ☐ No			
Unemployed from _____ to _____		Average Gross Monthly Income:	

Dependents:			
NAME	**AGE**	**NAME**	**AGE**

SPOUSE (if applicable)			
Name (*first, middle, last*):		Social Security Number:	
Address:		Birth Date:	
City:	State:	Zip Code:	County:
Employment Status: ☐ Full time ☐ Part-time ☐ Self-Employed ☐ Unemployed ☐ Retired			
Employer Name and address:			
Length of employment with current employer:		How often paid (Ex – Weekly/Bi-Monthly)	
Are you claimed on another tax return: ☐ Yes - Please explain _____ ☐ No			
Unemployed from _____ to _____		Average Gross Monthly Income:	

OTHER MONTHLY INCOME *(Please attach supporting documents)*					
Other Wages	$	Rental Income	$	Alimony/Child Support	$
Pension/Veterans Benefits	$	Disability Income/Work Comp	$	Unemployment	$
Rents/Royalties	$	Social Security	$	Interest/Dividends	$

PRIMARY EXPENSES:			
TYPE	**MONTHLY PAYMENT**	**ESTIMATED VALUE**	**UNPAID BALANCE**
Rental Payment	$	N/A	N/A
Primary Home	$	$	$
2nd Mortgage	$	$	$
Other Real Estate	$	$	$
If none identified above – please explain:			

AUTO/MOTORCYCLES/OTHER VEHICLES:			
TYPE/MAKE/MODEL/YEAR	**MONTHLY PAYMENT**	**ESTIMATED VALUE**	**UNPAID BALANCE**
	$	$	$
	$	$	$

OTHER ASSETS/INVESTMENTS:			
Current Checking Account	$	Savings Balance	$
Stocks/Bonds	$	Certificate of deposit (CD)	$
HAS/FSA	$	Other:	$
Land Sale Contracts	$	Other:	$
Real Estate Property	$	Real Estate Property	$

I certify that the above information is true and correct. I also understand that this information is subject to verification and if I have knowingly provided untrue information in this application I will be ineligible for financial assistance and will be responsible for any/all outstanding balance with Veterans Memorial Hospital.

SIGNATURE REQUIRED	
Patient/Responsible Party Signature	Date:
Spouse signature *(If Applicable)*	Date: