



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

<input type="checkbox"/> Medicaid Eligible, but not for date of service or for non-covered service	<input type="checkbox"/> Deceased with no estate
<input type="checkbox"/> Homeless – Explain:	<input type="checkbox"/> Incarceration in penal institution

Medical Assistance Eligibility (Please provide documentation of current status)

<input type="checkbox"/> I have applied for Medical Assistance	<input type="checkbox"/> Applied for – but not eligible
<input type="checkbox"/> I will be applying for Medical Assistance for effective date of :	<input type="checkbox"/> Other:

PLEASE ATTACH COPIES OF THE BELOW REQUIRED DOCUMENTATION, THEN COMPLETE AND SIGN THE APPLICATION

<input type="checkbox"/> Investment Statements (Ex – Bank CD’s, Investment earnings)	<input type="checkbox"/> Property tax statements
<input type="checkbox"/> Pay stubs for all sources of income reported from employers for 1 month	<input type="checkbox"/> Unemployment Earnings for 1 month
<input type="checkbox"/> Social security benefits	<input type="checkbox"/> Checking and savings bank statements
<input type="checkbox"/> Other – Describe:	<input type="checkbox"/> Mortgage balance statement
Filed Federal Income taxes:	
<input type="checkbox"/> Yes – Please provide the most recently filed Federal Income tax return and supporting schedules	
<input type="checkbox"/> 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:			
<input type="checkbox"/> Full time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> 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: <input type="checkbox"/> Yes - Please explain _____ <input type="checkbox"/> 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: <input type="checkbox"/> Full time <input type="checkbox"/> Part-time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> 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: <input type="checkbox"/> Yes - Please explain _____ <input type="checkbox"/> 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	\$	\$	\$
2 nd 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: