HUMBOLDT COUNTY MEMORIAL HOSPITAL
1000 North 15th Street
Humboldt, Iowa 50548
515-332-4200

APPLICATION FOR FINANCIAL ASSISTANCE

To assist us in the determination of your eligibility for possible financial assistance, the following application must be completed in full. **Return the completed form along with the required documentation to the hospital Business Office at the address above.**

Required documents:

- ☐ Most recent tax return
- ☐ Proof of income for the last 3 months
- ☐ Most recent bank statement
- ☐ Proof of residency (utility bill, property tax statement, etc)
- ☐ Current Public Assistance denial for medical assistance from your local Department of Human Services

NAME _____
Last name First name middle initial

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____

HOME ADDRESS _____
Street City State Zip

PHONE NUMBER:_____

How long have you lived at your current address? _____

Do you: ☐ own your home ☐ rent your home ☐ live with family/friends

SPOUSE & DEPENDENTS: (living in your household)

Name	Age	Relationship

EMPLOYMENT INFORMATION:

Employer's Name _____ Spouse's Employer _____

How long at current employer? _____ How long at current employer? _____

Are you self employed? _____ Do you have a secondary job? _____

If employed less than three months, please list previous employer information:

_____

If there are extenuating circumstances that would be helpful to us in understanding your need for financial assistance, please use this space to explain:

I / We hereby certify that I / We are of legal age and that the foregoing statements are true and complete and made for the purpose of determining my/our eligibility for financial assistance. I / We agree that this application shall remain the property of Humboldt County Memorial Hospital, whether or not the application is accepted. I / We agree to provide the necessary verification of my / our income. I/ We authorize the verification of any reported information on this application by Humboldt County Memorial Hospital.

_____ DATE _____
Signature of Applicant

_____ DATE _____
Signature of Spouse (if applicable)

HUMBOLDT COUNTY MEMORIAL HOSPITAL WILL REVIEW THE INFORMATION YOU HAVE PROVIDED AND YOU WILL RECEIVE WRITTEN NOTICE OF OUR DECISION.

Determination

( ) Full Financial Assistance
( ) Partial Financial Assistance
( ) No Financial Assistance Granted

Percentage due from Patient _____%

_____ DATE _____
Signature of Hospital Representative

SOURCES OF INCOME

Wages	$	Spouse's Wages	$
Second Job	$	Workers Compensation	$
Pensions	$	Public Assistance	$
Retirement/Soc Security	$	Inheritance	$
Unemployment	$	Military/Veterans Benefits	$
Alimony	$	Rent Income	$
Dividends / Interest	$	Other (specify)	$
Other (specify)	$	Other (specify)	$

OTHER ASSETS

Cash on hand	$	Land/ property	$
Checking account	$	Vehicle(s)	$
Savings account	$	Motorcycle / ATV	$
Stocks, bonds	$	Boats, RVs	$
Other resources	$		

Has application been completed for the following government assistance:

Disability / SSI	Yes	No	Approved	Denied
Title XIX				
Medically Needy				
General Relief				
Food Stamps				
Utility Assistance				
Other (specify)				

If you are not aware of these assistance programs, please contact your local Social Services Department or the Department of Human Services for more information.