HUMBOLDT COUNTY MEMORIAL HOSPITAL

CHARITY CARE APPLICATION

Thank you for inquiring about the Financial Assistance Program Charity Care at Humboldt County Memorial Hospital. Please fill out the attached application and return it with the required documentation below within 30 days. If your completed application has not been received within the specified timeline, your account will be subject to our standard billing procedures. When Humboldt County Memorial Hospital has received your completed application, it will be reviewed to determine your level of qualification. You will be notified of our determination within 30 days of receipt.

Applicants are required to apply for Medicaid before financial assistance will be considered. If you would like assistance completing your Iowa Medicaid application, or this application, please contact our Financial Counselor at (515)332-4200 located in the Business Office at Humboldt County Memorial Hospital.

Along with the completed application, copies of the following documents are also required. Any application returned without a signature, or the appropriate documentation will not be considered.

Documentation Check List: PLEASE DO NOT SEND ORIGINALS

- ☐ Last filed Federal Income Tax Return, if applicable (Must be within two years)
- ☐ Most Recent Bank Statement
- ☐ Three (3) Consecutive months of proof of income (e.g., pay-check stubs) – If on **Social Security**, please have a copy of the Benefit Verification Letter.
- ☐ Proof of DHS (Medicaid) Application; Notice of decision (If applicable)
- ☐ Proof of Residency (e.g., Utility bill, or mail with your physical address listed)

PLEASE NOTE: ELECTIVE PROCEDURES, HOSPITALITY STAYS, AND THE PAIN CENTER ARE NOT ELIGIBLE FOR CHARITY CARE.

UNSIGNED OR INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED FOR ASSISTANCE

Return the Charity Care application and required attachments to:

Humboldt County Memorial Hospital
Charity Care
1000 15th Street N
Humboldt, IA 50548

Or via Fax at (515) 332-7632

For assistance in completing this form or for any questions, please contact our financial counselor at 515-332-4200

HUMBOLDT COUNTY MEMORIAL HOSPITAL

1000 15th Street North, Humboldt, IA 50548
515-332-4200 | humboldthospital.org

Charity Care Application

To assist us in determining your eligibility for possible financial assistance, the following application must be completed in full.

Applicant Name: _____
Last Name First Name Middle Initial

Date of Birth: _____ Social Security #_____

Phone Number: _____
Home Work Mobile Phone

E-Mail Address (If applicable) _____

Preferred Method of Contact: _____

Home Address_____
Street City State Zip

How long have you lived at your current address? _____

Do you: Rent Own your Home Live with Family/Friends Residential Treatment Center

I have applied for or will apply for federal or state Medicaid assistance or have verified my healthcare exchange plan eligibility. Yes No Reason:
I have a lawsuit, settlement, personal Injury, or liability claim pending. Yes No Reason:

Applicant Employment Status: (Circle the choice that applies)

Full Time Part Time Self Employed Unemployed Retired Disabled

Employer Name: _____

Employment Length: _____ Unemployment Date/Length: _____

Spouse Employment Status: (Circle the choice that applies)

Full Time Part Time Self Employed Unemployed Retired Disabled

Employer Name: _____

Employment Length: _____ Unemployment Date/Length: _____

Spouse & Dependents: (living in your household) If more than 4 dependents use separate page.

Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:
Name:	Age:	Relationship:

Bank Accounts

Account Type	**Current Balance**
Checking	$
Savings	$
Other Investments and Securities	$

Property

Type	**Estimated Value**
Secondary Residence/Vacation Home	$
Land	$
Rental Property	$
Other/Recreational Vehicle	$

Provide documentation for any of the following sources of income.

Applicant

Income Description	**Source**	**Monthly Income Amount**
Primary Job Wages		$
Secondary Job Wages		$
Interest/Dividends		$
Pension/Retirement		$
Rental/Property		$
Disability/Social Security		$
Alimony/Child Support		$
Workers Compensation		$
Other		$

Spouse

Income Description	Source	Monthly Income Amount
Primary Job Wages		$
Secondary Job Wages		$
Interest/Dividends		$
Pension/Retirement		$
Rental/Property		$
Disability/Social Security		$
Alimony/Child Support		$
Workers Compensation		$
Other		$

Government Assistance

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

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 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.

Signature of Applicant: _____ Date: _____

Signature of Spouse: _____ Date: _____

Business Office Use Only:

FPL %age: _____

Approved Charity Care %age amount: _____%

Percentage due from the patient: _____%

Charity Care Active Dates: _____

Applicant Notified: _____

Notes:_____

_____

_____

Signature of Financial Counselor Date