Financial Assistance Application

To be completed in full & returned by: _____ Today's Date: _____

- Answer Each Question
- Use "NONE", if needed
- Please attach a copy of your most recent federal tax form (1040)
- Please attach current Payroll Stub

Please Return all Forms to:
Fort Madison Community Hospital
Att: Business Center
PO Box 174
Fort Madison, IA 52627

Tell us about the Patient:

Patient Name: _____ Date of Birth: _____

Account Number: _____

Person Responsible for the Bill:

Name:	Telephone Number:	
Social Security Number:	Date of Birth:	
Street Address:		
Mailing Address (If Different):		
City:	State:	Zip:

People in Your Home:

List all of the people who live in your home, including patient and/or self.
Use another sheet if needed.

Name (First, Last)	Date of Birth	Relationship to Responsible

Income: (You must attach income verification or we cannot process your application)

You must tell us about all of the money the people in your household get.
If you leave a space blank we will take that to mean there is no money of this kind.
Please use an additional sheet of paper, if needed. Attach paycheck stub or copy of tax form.

Where the money comes from	Who makes or gets the money	Amount per month
Money From Work Before Taxes (Gross)		
Self-Employment or Odd Jobs		
Tips, Bonuses and Commissions		
Unemployment or Worker's Compensation		
Social Security of SSI		
Veterans Benefits, Pensions or Retirement		
Child Support or Alimony		
Other		
Other		

Other Assistance:

Please tell us what programs the people in your household are currently enrolled in. Please place an ✘ in the box next to all that apply.

- ❒ I am currently unemployed
- ❒ I currently have no health insurance
- ❒ I am currently homeless
- ❒ I currently live in low income or subsidized housing
- ❒ I currently get food assistance
- ❒ I currently get energy assistance
- ❒ My child or children receive free or reduced lunches at the school they attend
- ❒ I currently receive child care assistance
- ❒ I am currently enrolled in the Wise Women Program
- ❒ I am currently enrolled in the Care For Yourself Program
- ❒ I am currently enrolled in WIC (Women, Infants and Children)
- ❒ I am currently enrolled in FIP (Family Investment Program), also knows an TANF

If you are claiming that you have no monthly income in dollars and/or no aid, please include an explanation of how you pay your monthly expenses such as telephone, rent, vehicle expenses, utilities, etc. Application will not be considered if not included.

ALL OF THE INFORMATION GIVEN TO FORT MADISON COMMUNITY HOSPITAL IS TRUE AND COMPLETE, AND MAY BE VERIFIED WITH THE LISTED INSTITUTIONS. I HEREBY AUTHORIZE FORT MADISON COMMUNITY HOSPITAL TO VERIFY ANY OR ALL INFORMATION GIVEN, AND I ALSO AUTHORIZE A CONSUMER CREDIT REPORT MAY BE OBTAINED.

Responsible party signature_____ Date/Time: _____

Spouse Signature:_____ Date/Time: _____