Crawford County Memorial Hospital
100 Medical Parkway
Denison, Iowa 51442
Phone: (712) 265-2500
Fax: (712) 265-2533

# TO APPLY FOR FINANCIAL ASSISTANCE

- Complete the financial assistance application enclosed
- Provide the Hospital with a letter from the Department of Human Services indicating if you do or do not qualify for the assistance from them.
- Proof of your income in the form of: copies of your latest State and Federal Income tax return, copies of your most recent bank statement and copies of your most recent pay stub.

Application must be completed and returned along with all required documentation to Crawford County Memorial Hospital by: _____.

# APPLICACION PARA ASISTENCIA FINANCIERA

- Complete la aplicación de asistencia financiera.
- Provea a Crawford County Memorial Hospital una carta del Departamento de Servicios Humanos indicando si usted si califico o no califico para la asistencia de parte del Departamento de Servicios Humanos.
- Prueba d ingresos en la siguiente forma: copias recientes de sus impuestos Estatales y Federales, copias del más reciente estado de cuenta bancario y un talón de pago

Por favor complete y regrese la aplicación y la documentación requerida por Crawford County Memorial Hospital para la Siguiente fecha: _____.

CRAWFORD COUNTY
MEMORIAL HOSPITAL

**Date Received**_____

# FINANCIAL ASSISTANCE APPLICATION

☐ Application is in Advance of Services ☐ Application is After Services Provided

As provided in the Crawford County Memorial Hospital Charity Care Policy, I hereby request consideration of my eligibility to receive reduced care at Crawford County Memorial Hospital/CCMH Medical Clinic.

**FILLING OUT THIS APPLICATION IS NOT A GUARANTEE OF ACCEPTANCE**

## Responsible Party / Applicant Information

| | | | | |
|---|---|---|---|---|
| Full Name | | | | Home Phone |
| Street Address | | | | Cell Phone |
| Mailing (If Different) | | | | Work Phone |
| City | | State | | Zip Code |
| Date of Birth | | SS# | | |
| Resident of Crawford County ___Yes | | ___No | | |
| Are you: | ❑ Pregnant | ❑ Blind | ❑ Disabled | ❑ Active-Duty Service (Military) |
| Marital Status: | ❑ Married | ❑ Separated | ❑ Divorced | ❑ Unmarried (Single or Widowed) |
| Employment | ❑ Not Employed Since _____<br>❑ Disability since _____ | | | ❑ Retired Since _____<br>❑ Laid off since _____ |
| Employer | | | | Hourly wage/salary $ |
| Employer Phone | | | | |
| City | | | State | |
| How Long Employed? | | How Often Paid? | | |

## Spouse / Significant Other Information

| | | | | |
|---|---|---|---|---|
| Full Name | | | | Cell Phone |
| Date of Birth | | SS# | | |
| Is spouse/significant other: | ❑ Pregnant | ❑ Blind | ❑ Disabled | ❑ Active-Duty Service (Military) |
| Employment | ❑ Not Employed Since _____<br>❑ Disability since _____ | | | ❑ Retired Since _____<br>❑ Laid off since _____ |
| Employer | | | | Hourly wage/salary $ |
| Employer Phone | | | | |
| City | | | State | |
| How Long Employed? | | How Often Paid? | | |

## Additional Household Members and Dependents

Total Family Size (include yourself and spouse/significant other): _____

- List All Other Legal Dependents Living in Household

| Name | Relationship | Date of Birth | Social Security # | Health Insurance Coverage? |
|---|---|---|---|---|
| | | | | □ Yes □ No |
| | | | | □ Yes □ No |
| | | | | □ Yes □ No |
| | | | | □ Yes □ No |
| | | | | □ Yes □ No |

If more family members than can be listed above, please attach an additional sheet of paper with the above information.

Please check any of the following that you have applied for and received in the past or are currently receiving:
❑Medicaid ❑HAWK-I (for children) ❑Iowa Care ❑Welfare/AFDC ❑WIC❑Food Stamps ❑ Fuel Assistance ❑ SSI

Have you ever been granted financial assistance at a hospital? ❑Yes ❑No

## Sources of Income

- List all household sources of income BEFORE taxes and deductions. Please use another piece of paper if needed.

| Source of Income or Money | Who Receives It | Amount Received Per Month |
|---|---|---|
| Money from Job (s) Before Taxes (Gross Income) Include odd jobs and tips | | |
| Unemployment, Worker's Compensation, Disability | | |
| Social Security or Supplemental Security Income (SSI) | | |
| Pensions, Retirement, or Veteran's Benefits | | |
| Child Support or Alimony | | |
| Regular Support from Family or Friends to assist with expenses | | |
| Other: | | |

## Cash Resources

- List all other cash resources for all members of the household.

| | | Name and City of Financial Institution/Bank | |
|---|---|---|---|
| Cash on Hand | $ | 1) | |
| Checking Account (s) | $ | 2) | |
| Savings Account (s) | $ | | |
| Savings Bonds/Stocks | $ | Employer Medical Flex Spending | $ |
| Certificates of Deposit | $ | Life Insurance Cash Value | $ |

*Do not list funds specifically held in trust for retirement, burial, or college education

## Liabilities

- Indicate your monthly expense for the following or total owed if requested.

| | Monthly Expense | Total Owed | | Monthly Expense | Total Owed |
|---|---|---|---|---|---|
| Mortgage/Rent | $ | $ | Other Bank Loans | $ | $ |
| Car Payment | $ | $ | Medical Debt | $ | $ |
| Insurance-All Types | $ | N/A | Prescriptions | $ | N/A |
| Credit Cards | $ | $ | Other: | $ | $ |

## Additional Information

- Please send copies of all the items below

1. Copy of your most recent federal tax return and State Taxes.
2. Copy of last two pay stubs from all employers for all household members for this year
3. Copy of most recent bank Statement(s)
4. Copy of DHS approval or Denial Letter

All the information provided above is true and correct to the best of my knowledge. I understand that providing any false or misleading information may result in denial of this application. I grant CCMH, its affiliates and representative permission to investigate the information provided.

Signature of Applicant _____Date _____

Best time of day to reach _____at Number _____

*Revised 04/26/2012*