Financial Assistance Application Information

To Whom It May Concern:

In accordance with the Iowa Health System's mission to improve the health of our community through healing, caring, and teaching, Trinity Regional Medical Center will provide health care services to all patients regardless of their ability to pay.

- ✓ **If you are eligible for Housing assistance, Food Stamps, Medicaid Programs or Iowa Cares Program, please provide documentation showing your current monthly eligibility.**

To determine if you qualify for financial assistance, you will need to complete the attached application, in its **entirety.** You will also need to provide ***copies*** of the following documents to support your income.

__**X**__ Your most recent complete Federal Income Tax Form **with** W2's. (Complete tax form, not summary)

__**X**__ Paycheck stubs for past 3 months or written Statement of Earnings from your employer listing dates of employment with year to date income and per hour wage and hours. Proof of any Worker Compensation payments is also required.

_____ A Workforce Center printout showing the status of reported income from employment (Wage A statement), along with proof of any payments from unemployment (DBRO statement).

_____ Proof of **current gross** monthly Social Security benefit from the government. (Copy of letter you received or Social Security printout)

Items with an "X" next to them **must** be returned with the application. If the other two items apply to you, please enclose those also.

If there are additional comments that require further explanation, please write the information on the back of your application.

Enclosed is an envelope for the return of the application.

If you have any questions about this application please feel free to call our customer service number at 1-515-574-6627.

Trinity Regional Medical Center
802 Kenyon Road
Fort Dodge, Iowa 50501
515-574-6627

Please return completed application to Trinity Regional Medical Center

PATIENT INFORMATION:

Patient's Name: ______________________________ Telephone: ______________________________
(Last) (First) (MI)
Address: ______________________________ Birth Date: ______________ Age: ________
(Street)
______________________________ Soc. Sec. #: ______________ Marital Status: ______
(City) (State) (Zip)

PERSON RESPONSIBLE FOR ACCOUNT BALANCE(S) DUE:

Name: ______________________________
(Last) (First) (MI)
Address: ______________________________
(Street)
____
(City) (State) (Zip)
Telephone: ______________________________
Birth Date: ______________________________
Soc. Sec. #: ______________ Marital Status: ________

Employer: ______________ Start Date: ________
Employer Address: ______________________________
(Street)
____
(City) (State) (Zip)
Telephone: ______________________________
Job Title: ______________________________
Job Status: FT / PT Average Weekly Hrs: ____________

SPOUSE OF PERSON RESPONSIBLE FOR BALANCE(S) DUE:

Name: ______________________________
(Last) (First) (MI)
Address: ______________________________
(Street)
____
(City) (State) (Zip)
Telephone: ______________________________
Birth Date: ______________________________
Soc. Sec. #: ______________________________

List All <u>Other Person</u> (s) Living in the Household

Full Name Relationship Age/DOB

____
____
____
____
____
____

Employer: ______________ Start Date: ______
Employer Address: ______________________________
(Street)
____
(City) (State) (Zip)
Employer Telephone: ______________________________
Job Title: ______________________________
Job Status: FT/PT Avg Weekly Hrs: ______________

**** **Second Employer (if any):**
Employee Name ______________________
Employer: ______________ Start Date: _____
Employer Address ______________________________
____
____
(City) (State) (Zip)
Employer Telephone ______________________________
Job Title ______________________________
Job Status: FT / PT Average Weekly Hours ______________

Source of Income Information

	Your Monthly Gross Income	Spouse's Monthly Gross Income
Income from Employment	Paid: __monthly __biweekly __weekly	Paid __monthly __biweekly __weekly
Income from Social Security		
Income from Child Support/Alimony		
Income from Pension/Compensation		
Income from Interest/Dividend		
FIP/Family Investment Program		
Other (Explain)		
Total Gross Monthly Income		

Assets /Value

Amount / Balance Bank or Credit Company Name__________

Checking Account (Balance)

Savings Account (Balance)

Stocks/Bonds/CD's (Balance) __________

401K / Pension Plan (Balance) ___

Motor Vehicles (Make/Model/Blue Book Value) __________

Primary Residence (Market Value)

Other Property (Market Value) ___

Total Assets

Liabilities : Balances Owed-Monthly Payments

Item	Total Amount Owed	Monthly Payments	Bank / Credit Co
Home Mortgage (Balance/ Monthly Payment)			
Second Home Mortgage (Balance/Monthly Payment)			
Rent (Monthly Pmts)			
Monthly Utilities (G&L, Water, Phone, Cable, Cell phone)			
Medical bills owed			
Prescriptions (Monthly)			
Bank Loans-Auto (Balance/Monthly Payment)			
Bank Loans-Personal (Balance/Monthly Payment)			
Insurance-Auto, Medical , Life (Monthly)			
Credit Card Debt (Balance/Monthly)			
Child Support (Monthly)			
Total Liabilities			

CONSENT FOR RELEASE OF INFORMATION

I certify all information is true and correct to the best of my knowledge. I understand that provision of any false or misleading claims, statements, documents or concealment of a material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Trinity Regional Medical Center, its affiliates and representatives to investigate the information contained herein.

I also agree to notify Trinity Regional Medical Center of any changes in my financial position that would impact this determination.

Applicant's Signature Date

Applicant Spouse's Signature Date

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EACH LINE ITEM NEEDS AN ANSWER
If a line item does not apply to your circumstances, put a zero or write none on that line item