



FINANCIAL ASSISTANCE

Return Completed form to:
Hancock County Memorial Hospital
Attn: Director-Patient Financial Services
532 1st Street NW
Britt, IA 50423

We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance. Financial assistance is based on Federal Poverty Income Levels. **Incomplete forms will not be processed. Income verification such as previous Income Tax Return or three month's of paycheck stubs must be submitted for this form to be considered complete.**

Applicant:		Spouse:	
SSN:	DOB:	SSN:	DOB:
Address: _____ City/St _____		Address: _____	
Phone/Cell Phone: _____			
1. Household Gross Monthly Income: (Include all taxable income, wages, salary, tips, child support, etc.) \$ _____			
Other Income: \$ _____ List: _____			
If Income is \$0.00 (zero) explain:			
2. Resources:		IRA:	
Checking Account Balance: \$ _____		Stock/Bonds: \$ _____	
Savings Account Balance: \$ _____		Other Property: \$ _____	
3. Dependents:	Name	Date of Birth	Name
	1 _____	_____	3 _____
	2 _____	_____	4 _____
4. Housing Expense: Renting/Own/Buying Payment: \$ _____			
Property Value: \$ _____ Balance Owing: \$ _____			
5. Auto Expenses: (List year, make, model and payment amount for all cars, trucks.)			
6. RV/Boat/ATV: (List type, year, and payment.)			
7. Support Payments: (Any support payments ordered by the court and made by the person.)			
8. Monthly Expenses: (Medication expenses require documentation from your pharmacy.)			
9. Please indicate other financial assistance programs applied for within the last year (social security, disability, Medicaid, etc.):			
Please provide or attach any information you feel would be helpful in understanding your current situation.			
CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. I understand that I must provide verification of income, expenses, dependents, bank statements, by pay voucher and tax statements. I understand that a credit report may be used as part of the assistance determination process.			
Patient Signature: _____		Date: _____	
Office Use Only:			
Approval:	YES	NO	If yes, Percentage Approved: _____
CFO: _____	Director-Patient Financial Services: _____		
Date: _____			