Greene County MEDICAL CENTER
Always Here, Always Caring

An Affiliate of UnityPoint Health

FINANCIAL ASSISTANCE APPLICATION

Thank you for inquiring about the Financial Assistance program at Greene County Medical Center. 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 time, your account will be subject to our standard billing procedures. When Greene County Medical Center 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 through the medical center will be considered. If you would like assistance completing your Iowa Medicaid application, or this application, please contact our Financial Counselor, at (515) 386-0278. They are located in the Business Office at the medical center and will also be available to discuss other financial assistance options for which you may qualify.

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
- ☐ Three (3) consecutive months of proof of income (pay-check stub, letter from employer)
- ☐ Three (3) consecutive months of last statement for: checking, savings, stocks, bonds, CDs, 401k, IPERS, life insurance
- ☐ Proof of DHS (Medicaid) application; Notice of decision (if applicable)

PLEASE NOTE THAT ELECTIVE PROCEDURES MAY NOT BE CONSIDERED FOR ASSISTANCE.

- ☐ I certify all information on this application is true and correct to the best of my knowledge. I understand that provision of any false or misleading information or concealment of a material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Greene County Medical Center to contact the organizations listed on this application to verify information given on this application.

Applicant Signature: _____Date:_____

UNSIGNED APPLICATIONS WILL NOT BE REVIEWED FOR ASSISTANCE

APPLICATION FOR FINANCIAL ASSISTANCE:

STEP 1: COMPLETE INFORMATION BELOW: (ALL QUESTIONS MUST BE ANSWERED)

PATIENT NAME:	SOCIAL SECURITY # (REQUIRED):
ADDRESS, CITY, STATE, ZIP:	BIRTH DATE:
HOME PHONE #:	CELL PHONE #:
EMPLOYER NAME & ADDRESS:	EMPLOYER PHONE#:
# OF HOURS WORKED PER WEEK:	GROSS MONTHLY WAGE:
MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED SEPARATED WIDOWED	

NAME OF THOSE IN THE **HOUSEHOLD**	SEX	SS#	D.O.B	RELATION TO PATIENT	MONTHLY GROSS WAGES	EMPLOYER NAME	EMPLOYER PHONE NUMBER

CHECKING ACCOUNT **YES / NO**	BALANCE:	SAVINGS ACCOUNT **YES / NO**	BALANCE:
STOCKS, BONDS, IRA, CD, **YES / NO**	BALANCE:	4O1K, IPERS **YES / NO**	BALANCE: CASH VALUE:

DO YOU HAVE LIFE INSURANCE FOR YOU OR ANY DEPENDANT OVER 21 WITH A CASH VALUE? **YES / NO** **CASH IN VALUE:**	DO YOU CURRENTLY OWN, OR ARE YOU BUYING REAL ESTATE PROPERTY: **YES / NO**

PERSONAL PROPERTY: PLEASE LIST ALL CARS, TRUCKS, MOTORCYCLES, CAMPERS, OR ANY OTHER RECREATIONAL OR NON-RECREATIONAL VEHICLES. IF MORE SPACE IS REQUIRED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER.

ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:
ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:
ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:

- If unemployed, provide the date employment ended_____. Have you applied for unemployment? **YES / NO**
- If there is no reported income, have you applied for disability? **YES / NO** Are you planning on applying? **YES / NO**
- Have you applied for Medicaid? **YES / NO** Date applied**_____.**
- Did the applicant have insurance at the time of this visit? **YES / NO If yes, please fill out the following information:**

NAME OF INSURANCE:	**EFFECTIVE DATE:**
NAME OF POLICYHOLDER:	**POLICY NUMBER:**

GROSS MONTHLY HOUSEHOLD INCOME: **MONTHLY EXPENSES:**

WAGES		RENT/ MORTGAGE		CREDIT CARD MINIMUM	
SOCIAL SECURITY		HOME INSURANCE		LOANS	
CHILD SUPPORT		PROPERTY TAXES		MEDICAL BILLS	
ALIMONY		PHONE/ INTERNET		STUDENT LOANS	
PUBLIC ASSISTANCE**		CELL PHONE		FOOD	
FOOD STAMPS **		GAS/ ELECTRIC		CHILD CARE	
PENSION/ COMPENSATION		WATER/ SEWER		MEDICATION	
INTEREST/ DIVIDENDS		CABLE/ DISH		CAR PAYMENT	
UNEMPLOYMENT		LIFE INSURANCE		RECREATIONAL VEHICLE PAYMENT	
OTHER		AUTO INSURANCE		OTHER	
TOTAL		HEALTH INSURANCE		**TOTAL**	

** Please provide proof/documentation of the Public Assistance & Food Stamps

ADDITIONAL INFORMATION: