STEWART MEMORIAL COMMUNITY HOSPITAL
1301 W. Main, Lake City, Iowa 51449
712-464-3171

FINANCIAL ASSISTANCE APPLICATION

Name: _____
First Middle Last
Address:_____
City State Zip

D.O.B: _____Social Security #: _____
Cell/Home Phone: _____ or Message Phone: _____
Occupation: _____ Employer:_____
Phone: _____
Do you have insurance coverage on any of your bills? _____
Have you applied for Medical Assistance from Human Services?_____
If yes, include copy of their determination letter.
If no, apply with your county's DHS and enclose a copy of their determination letter.

PRE~SUMPTIVE ELIGIBILITY:
Presumptive Eligibility: If you have already qualified for one of the following programs, please submit documentation supporting your eligibility.
✔ Food Stamps
✔ Family Investment Program
✔ Limited eligibility - Emergency 3 day County & State relief programs, i.e. fuel assistance, WIC, etc.

Income: List income from all family members from the following sources:

Source	**Monthly Amount**
Gross wages, salaries, tips, etc.	
Income from business, self-employment, and dependents	
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pensions, or retirement income	
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources	
Total Income	

Verification of income is required. You must supply the Business Office with a copy of your last 1 year income tax returns and a complete copy of your last 2 bank statements. Current pay stubs from all employers for all persons including children over the age of 19 that have resided in the household more than 6 months out of the last 12 months. **The following information must be completed in full and returned to the hospital within 30 days of receipt.**
Social Security Number, Medical Assistance (determination letter), Assets and Monthly Expense Section is optional for patients of the Emergency Room and Outpatient clinics.

Stewart Memorial Community Hospital complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-712-464-4203.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-712-464-4203.

(Please complete next page)

Total number in household over the last 12 months _____
Dates of hospitalization that assistance is requested for: _____
_____
_____

Spouse/Dependents

Name	Age	Relationship
_____		
_____		

I certify that the above information is true and accurate to the best of my knowledge. If any information I have given proves to be untrue, I understand that the hospital may re~evaluate my financial status and take whatever action becomes appropriate.

_____ _____
Signature Date

If there are extenuating circumstances that would be helpful to us in understanding your need for financial assistance, please use the space below to explain.

DETERMINATION OF ELIGIBILITY
OFFICE USE ONLY

Date Application Received: _____
Total Bill: _____

_____ The Applicant is eligible for Financial Assistance

_____ Percent Assistance

_____ The Applicant's request for Financial Assistance has been denied for the following reason(s):

_____Household income exceeds 200% of FPIG

_____Application is incomplete

Date of Determination of Eligibility: _____

Date Applicant Notified: _____

Signature: _____
(Person making the determination)

MONTHLY EXPENSES

Type	Monthly Amt	
House Payment/Rent		Circle one: Own Rent Other _____
Utilities		
Electric		
Gas		
Water, etc.		
Phone/Home		
Phone/Cell		
Cable TV		
Groceries		
Child Care		
Clothing		
Property Taxes		
Child Support		
	Monthly Amt	Remaining Balance
Auto:		
Auto Loan(s)		
Auto Insurance		
Auto Gas		
Auto Repair		
Life Insurance		
Health Insurance		
Credit Cards (please list)		

(Please complete next page)

Type	Monthly Amt	Remaining Balance
Medical Debt.		
Facility		
Doctor(s) name		
	Monthly Amt	
ASSETS	DESCRIPTION	VALUE IN DOLLARS
Cash on hand &: in bank		
Stocks/bonds/CDs		
Real Estate Owned		
Automobiles		
Recreational Vehicles		
Life Insurance ~cash value		
Other Assets ~ Itemized		