

**MADISON COUNTY HEALTH CARE SYSTEM
FINANCIAL ASSISTANCE PROGRAM APPLICATION**

I. IDENTIFYING INFORMATION:

Members of household including yourself, spouse, significant other, dependants (full-time students <25):

	Name	Relationship	Date of Birth	Sex
Responsible Party (Self)		SELF		
Spouse or Significant Other				
Dependant 1				
Dependant 2				
Dependant 3				
Dependant 4				
Dependant 5				

*Please continue on the back of this application if you have more than 5 Dependents.

Street Address	City	County	State	Zip Code

Mailing Address (if different from above):	Telephone Number(s):
	Home:
	Work:
	Cell or Other:

Why are you requesting Financial Assistance?:

- Unemployed? Yes No If you or your spouse is working, please fill out the below chart.
- Retired? Yes No

CURRENT EMPLOYMENT OF SELF & SPOUSE:

Person	Employer	Date Began	Date Ended	Reason for Leaving
Self: Primary Job				
Self: Secondary Job				
Spouse: Primary Job				
Spouse: Secondary Job				
Other				

- Have you applied for Disability? Yes No
 Have you applied for SSI (Supplemental Security Income)? Yes No

II. INCOME

Does anyone in your home have any of the following resources? Check “Yes” or “No” for each item. For each item checked “Yes” indicate the amount received and frequency. Provide required documentation as indicated for items checked “Yes”.

Source of Income	Check One	Amount	How frequently is income received?	Provide Required Documentation
FIP-Family Investment Program	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Self Employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Federal Income Tax Return
Employment:		\$		Federal Income Tax Return
Self – Primary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Federal Income Tax Return
Self – Secondary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Federal Income Tax Return
Spouse – Primary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Federal Income Tax Return
Spouse – Secondary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Federal Income Tax Return
Unemployment, Worker’s Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Federal Income Tax Return
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Railroad Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Supplemental Security Income (SSI)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Veterans Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Child Support-Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Military Dependency Allotment/Allowance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Disability Insurance Payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
IPERS, Civil Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Other Pension/Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Money from other persons, gifts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Dividend/Interest payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Room and/or Board Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Commissions or other lump sum payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Health Policies paying you income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Supporting Documentation
Other (Explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

III. PRESCRIPTION MEDICATION EXPENSES

Monthly Prescription Medication Cost for Self, Spouse, and legal dependants: \$ _____

Attach supporting documentation if medication expense is greater than \$100.00 per month.

This can be copies of receipts or a print out from your pharmacy for the past 12 month.

IV. HEALTH INSURANCE

Have you applied for Medicaid (Title 19)? Yes No

- **IF NO,** We may send your information to DHS or review internally. If DHS indicates that you may qualify for Medicaid, you will be required to apply for Medicaid coverage before being considered for Madison County Health Care System’s Financial Assistance Program.
- **IF YES,** Please provide a copy of your DHS Notice of Decision.

Do you have Medicaid (Title 19)? Yes No (Provide copies of all family member’s cards)

If YES, do you have a spenddown? Yes No

If YES, what is your monthly spenddown amount? \$ _____

If you have dependents <19 years old, have you applied for the HAWK-I program? Yes No

Please list current Health Insurance for anyone listed on this application:

Insurance Name: _____ ID#: _____

Policy Holder Name: _____

Names of covered family members: _____

Insurance Name: _____ ID#: _____

Policy Holder Name: _____

Names of covered family members: _____

V. RESOURCES

Does anyone in your home have any of the following resources? Check “Yes” or “No” for each item. Complete the information line for items checked “Yes.”

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Amount	Bank or Location	Account in the Name of:
Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Checking Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Savings Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Stocks/Bonds	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Time Certificates	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Conservatorship/Trust	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Safety Deposit Box	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

	<input type="checkbox"/> Yes <input type="checkbox"/> No	Year, Make & Model	Amount Owed	
Automobile	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Automobile	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Truck(s)/Motorcycles	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Snowmobiles/Boats	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Mobile Home/Camper	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	
Other (Specify)	<input type="checkbox"/> Yes <input type="checkbox"/> No		\$	

Are you or your spouse buying real estate other than your homestead? Yes No

Do you or your spouse own any real estate other than your homestead? Yes No

Has anyone in your home received anything with cash value in the last two years (i.e., gifts, inheritance, winnings, settlements, etc.)? Yes No

If yes, list item and cash value \$ _____

CERTIFICATION STATEMENT

Note: Read carefully before signing.

(If completing online, please print entire application, sign and return to the Patient Accounts Office.)

I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand that Madison County Health Care System will use these statements to determine my eligibility for the Financial Assistance Program. If any information changes, it is my responsibility to contact Madison County Health Care System to report such changes. I further understand that any false representations or false claims, statements, or documents or concealment of a material fact may result in the immediate termination of any financial assistance granted to me or my family and that I will be liable to repay all amounts of financial assistance previously provided to me.

I understand that Madison County Health Care System may contact other agencies referenced in this application including the Department of Human Services to confirm statements made in this application and to obtain information that may be necessary to establish my eligibility for the Financial Assistance Program. My signature below shall authorize such mutual exchange of information between Madison County Health Care System and appropriate agencies or persons.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. **(Each adult listed on this application must sign)**

Signature of Applicant (or legal guardian)

Date

Signature of Spouse or Significant Other (if applicable)

Date

PROHIBITION AGAINST DISCRIMINATION

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

RIGHT OF APPEAL

If you are not satisfied with the action of this office, you may appeal to the Chief Executive Officer of Madison County Health Care System, 300 Hutchings, Winterset, IA 50273. (515) 462-2373

Please provide the following items (if applicable) in order for your application to be processed:

- | | |
|---|--|
| <input type="checkbox"/> Copy of DHS Notice of Decision for Medicaid (Title 19) | <input type="checkbox"/> Medication receipts or print out from pharmacy (if medication payments total over \$100 per month) |
| <input checked="" type="checkbox"/> Most recent Federal Income Tax Return (Required) * | <input type="checkbox"/> Other Expense Receipts or Income Documents |

***If most recent Federal Income Tax Return is not available, please contact our office at 462-9747.**