

**DAVIS COUNTY HOSPITAL**  
**FINANCIAL ASSISTANCE PROGRAM APPLICATION**

**Please note:** A complete financial assistance application (including all required documentation) must be received at Davis County Hospital **within 1 year from the date you receive services** to be eligible.

**I. IDENTIFYING INFORMATION:**

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

	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.

Maiden name or any other name known by:

Self: \_\_\_\_\_ Spouse: \_\_\_\_\_

Your Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

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?

- **PLEASE ATTACH LETTER OF EXPLANATION**

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

- **IF NO, WE WILL SEND YOUR INFORMATION TO DHS. IF THEY INDICATE THAT YOU MAY QUALIFY FOR MEDICAID, YOU WILL BE REQUIRED TO APPLY FOR MEDICAID COVERAGE BEFORE BEING CONSIDERED FOR DAVIS COUNTY HOSPITAL'S FINANCIAL ASSISTANCE PROGRAM.**
- **IF YES, PLEASE PROVIDE A COPY OF YOUR DHS NOTICE OF DECISION.**

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

Have you applied for Disability?  Yes  No

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

Veteran Status:  Yes  No If yes, date of service \_\_\_\_\_

**II. INCOME**

Does anyone in your household have any of the following resources? Check “yes” or “no” for each item. Complete columns C & D and provide required documentation as indicated in Column E for items checked “yes”.

**MONTHLY**

A	B	C	D	E
Source of Income	Check One	Amount	How often 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:		\$		Last 3 months pay stubs
Self – Primary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Last 3 months pay stubs
Self – Secondary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Last 3 months pay stubs
Spouse – Primary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Last 3 months pay stubs
Spouse – Secondary Job	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Last 3 months pay stubs
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Last 3 months pay stubs
Unemployment, Worker’s Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Last 3 months pay stubs
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	\$		
Child Support-Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		Documentation of payments received
Military Dependency Allotment/Allowance	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Disability Insurance Payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
IPERS, Civil Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Other Pension or Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Money from other persons, gifts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Money from interest dividends	<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	\$		
Other (Explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

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

**CURRENT EMPLOYMENT OF SELF, SPOUSE & OTHER (if applicable):**

Person	Employer	Date Began	Date Ended	Monthly Wages	Reason for Leaving
Self: Primary Job				\$	
Self: Secondary Job				\$	
Spouse: Primary Job				\$	
Spouse: Secondary Job				\$	
Other				\$	

### III. HEALTH INSURANCE

A	B	C
Policy	Circle One	Comments
Do you have Medicaid (Title 19)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Provide copies of all family members' cards.  <b>If you have applied for Medicaid, please provide a copy of your DHS Notice of Decision.</b>
If No, have you applied for Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Were you approved?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, do you have a spenddown?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
What is your spenddown amount?	\$ _____	
Do you have Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, fill in Insurance information below.
If No, have you applied for Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date applied: _____
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, fill in Insurance information below.

Insurance Name: \_\_\_\_\_ ID#: \_\_\_\_\_  
 Policy Holder Name: \_\_\_\_\_  
 Names of covered family members: \_\_\_\_\_  
 \_\_\_\_\_

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 Policy Holder Name: \_\_\_\_\_  
 Names of covered family members: \_\_\_\_\_  
 \_\_\_\_\_

- Please provide copies of CURRENT Insurance Cards and indicate covered family members.

### IV. RESOURCES

Does anyone in your household have any of the following resources? Check "yes" or "no" for each item. Complete the information line for items checked "yes."

		Amount	Location	Name(s) of Person	Provide Required Documentation
Cash	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			
Checking Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			Most recent past 3 months
Savings Account	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$			Most recent past 3 months
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	\$			

### V. 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.)

## CERTIFICATION STATEMENT

Note: Read carefully before signing.

I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand that Davis County Hospital will use these statements to determine my eligibility for the Financial Assistance Program. If any information changes, it is my responsibility to contact Davis County Hospital 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 Davis County Hospital may contact other agencies including Davis County 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 Davis County Hospital 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 Davis County Hospital, 509 N. Madison St., Bloomfield, IA 52537. (641) 664-7080

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

- |   |   |
|---|---|
| <input type="checkbox"/> <b>Copy of your DHS Notice of Decision for Medicaid (Title 19)</b>                         | <input type="checkbox"/> <b>Copies of Insurance Cards (Please indicate names of covered family members)</b> |
| <input type="checkbox"/> <b>Most recent Federal Income Tax Return</b>   | <input type="checkbox"/> <b>Medication receipts/summary</b>   |
| <input type="checkbox"/> <b>Copies of proof of income (i.e. paycheck stubs) for the most recent past 3 months</b>   | <input type="checkbox"/> <b>Letter of explanation of your current situation</b>                             |
| <input type="checkbox"/> <b>Copies of bank statements (i.e. checking/savings) for the most recent past 3 months</b> | <input type="checkbox"/> <b>Proof of student status</b>   |
| <input type="checkbox"/> <b>Copies of all other unpaid outstanding medical debt (i.e. other hospitals/clinics)</b>  |   |