EASTERN IOWA HEALTH CENTER

Annual Financial Assistance Application

Date_____

If you would like to be evaluated for Eastern Iowa Health Center's financial assistance program, **you will need to complete this application and provide documentation regarding your family's gross annual income (total family income before taxes) within 3 weeks of application date.**

Patient Information

Name:_____ Date of Birth:_____ SSN:_____

Address:_____

Housing: ☐Own/Rent (if month-to-month ☐) ☐Shelter ☐Transitional ☐Doubling-up ☐Street ☐Other_____

Phone No:_____ Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Spouse/Partner's Name:_____ Date of Birth:_____ SSN:_____

Dependent's Name:_____ Date of Birth:_____ SSN:_____

Dependent's Name:_____ Date of Birth:_____ SSN:_____

Dependent's Name:_____ Date of Birth:_____ SSN:_____

Dependent's Name:_____ Date of Birth:_____ SSN:_____

Dependent's Name:_____ Date of Birth:_____ SSN:_____

Is anyone in the family covered by Medical/Dental insurance? ☐Yes ☐No

If yes, please list whom:_____

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I DO NOT WISH TO DISCLOSE MY INCOME. I AM NOT INTERESTED IN RECEIVING ANY FINANCIAL ASSISTANCE. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR 100% OF ALL CHARGES. ***Please sign below and return form.***

☐ I DECLARE THAT MY FINANCIAL STATUS IS AS LISTED ON THE SELF DECLARATION PAGE. I REALIZE EIHC IS USING FEDERAL TAX DOLLARS TO ASSIST ME IN RECEIVING CARE. I UNDERSTAND THAT ANY MISREPRESENTATION OF INFORMATION REGARDING MY INCOME IS CONSIDERED FRAUD AGAINST THE U.S. GOVERNMENT.

Gross Income for Members of Household

DOES ANY HOUSEHOLD MEMBER LISTED ABOVE RECEIVE					
Employment Wages?	☐ Yes	☐ No	Unemployment Wages?	☐ Yes	☐ No
Social Security (SSI)?	☐ Yes	☐ No	Self-Employment Wages?	☐ Yes	☐ No
Social Security Disability (SSDI)?	☐ Yes	☐ No	Workers Compensation?	☐ Yes	☐ No
Retirement Benefits/Pension?	☐ Yes	☐ No	Other Income/Support?	☐ Yes	☐ No
			Alimony/Inheritance?	☐ Yes	☐ No

YOU WILL NEED TO PROVIDE ONE OF THE FOLLOWING FORMS OF DOCUMENTATION:

Paycheck stubs (4 consecutive weeks of pay)

Tax return (most recent tax year if no significant changes)

IF YOU DO NOT HAVE THE DOCUMENTATION LISTED ABOVE, YOU WILL NEED TO INCLUDE DOCUMENTATION FOR ALL THAT APPLY BELOW:

- Disability Statement
- Social Security Statement
- Form SSA-1099; Social Security Statement
- Printout from Iowa Workforce
- Pension Statement
- Veteran's Benefit Statement
- Worker's Compensation
- Documentation of any other source of income

I hereby certify that the above information is true. I understand that I will be responsible for 100% of the charges until Eastern Iowa Health Center receives this application and proof of income. I understand that I have 3 weeks from the date of this application to provide this information. I understand I must contact a Patient Advocate at Eastern Iowa Health Center if a change occurs with my household size, income, or if someone on this application becomes eligible for insurance.

_____ _____ _____

Patient or Responsible Party Signature | Relationship to Patient | Date

For Office Use Only – Leave Blank

Date:		**Staff Person:**		**Family Size:**		**Annual Income:**
A	**B**	**C**	**D**	**Homeless**	**Self-Pay**	**Expiration Date:**
Slide(s) entered in Athena:		**UDS Income Level Correct:**		**1st Call:**	**2nd Call:**	**Reviewed by:** **Date:**