Regional Health Services of Howard County
235 8th Ave West, Cresco, IA 52136
Phone: 563-547-6311, Fax: 563-547-6642

Appendix F

RHSHC FINANCIAL ASSISTANCE

Please complete if you feel you are in need of financial assistance or payment extension. We are required to inform **all** patients of the availability of this program. We are required by law to keep information about you confidential. The information below will only be used for the purpose of confirming your need for financial assistance or payment extension. Financial assistance is based on Federal Poverty Income Levels.

Applicant:	Other Adult resident of household:
SSN: DOB:	SSN: DOB:
Address:	Address:
Phone/Cell Phone:	County of Residence

Please check appropriate box: I am applying for a payment extension ☐ I am applying for financial assistance ☐

1. Household Gross Monthly Income:(Include all taxable income, wages, salary, tips, child support, etc) $_____
If this amount is different than the total on your tax return please explain. _____

_____

This should represent all adult residents of the household.
Other Income: $_____ List: _____

If Income is $0.00(zero) explain:

2. Resources:	IRA: _____
Checking Account Balance: _____	Stocks/Bonds: _____
Savings Account Balance: _____	Other Property: _____

3. Dependents: Name	Date of Birth	Name	Date of Birth
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

4. Housing Expense: Renting Own/Buying Payment: $ _____

Property Value: $_____ Balance Owing: $_____

5 Auto Expenses: (List year, make, model for all cars, trucks)

6 RV/Boat/ATVs: (List type, year):

7 Support Payments: (Any support payments ordered by the court and made by the person)

8. Monthly Expenses – **List monthly expenses on the form provided on the back of this form.**

9. Please indicate other financial assistance programs applied for within the last year (social security disability, Medicaid, etc)

**Please provide or attach any information you feel would be helpful in understanding your current situation. **

CLIENT AFFIRMATION: I affirm that the statements made herein are true and correct to the best of my knowledge. I understand that any false statements or misstatements of material fact could result in disqualification for financial assistance. I understand that a credit report may be used as part of the assistance determination process. **Incomplete forms will not be processed. I understand that I must provide verification of income, expenses, dependents, bank statements, pay vouchers and tax statements for this form to be considered complete.**

Are you over age 21? _____ Are you under age 65? _____ Are you pregnant? _____
Are you receiving social security disability? _____ Do you have dependent children? _____

Appendix F

Monthly Expenses

Rent/Mortgage Payment	_____	Automobile Payment	_____
Daycare Payment	_____	Car/Home Insurance Payment	_____
Heating (LP, natural gas)	_____	Health Insurance	_____
Cable (Direct TV/dish)	_____	Home/Cell Phone	_____
Electricity	_____	Water/Garb/Sewer	_____
Groceries	_____	Membership/Dues	_____
Medical Payments	_____	Tuition	_____
Credit Card Payment	_____	Child Support Payments	_____
Other	_____		

Total Monthly Expenses: _____

Before the application can be submitted for review, I will need the following information:

_____ **Copies of your 2020 tax return (showing gross income of all adults residing in the household) SEND YOUR PERSONAL TAX RETURN OR YOUR LAST 2 RECENT PAYSTUBS IF YOU DO NOT FILE TAXES**

_____ **Copy of most recent Itemized Bank Statement (showing balance of all accounts in the last 30 days)**

_____ **Denial from the Department of Human Services (Medicaid) Call 1-855-889-7985 or go to www.iowadhs.gov.**

With this information we may be able to access some assistance for you.

Accounts listed with our Collection Agency are not eligible.

This information is needed within 21 working days of the receipt of this letter.

If you have any questions please call our billing office at 563-547-6311.

Patient Signature: _____ Date: _____