CHEROKEE REGIONAL MEDICAL CENTER
300 Sioux Valley Drive
Cherokee, Iowa 51012

FINANCIAL ASSISTANCE APPLICATION

Name: ____
First Middle Last

Address: ____
City State Zip

D.O.B: ____________________Last 4 Digits of 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. You do NOT need to complete the remainder of this application.

- ✓ 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:

	Monthly Amount
Gross Wages	___________________________
Farm or self-employment	___________________________
Unemployment Compensation	___________________________
Workman's Compensation	___________________________
Alimony	___________________________
Child Support	___________________________
Pensions	___________________________
Social Security	___________________________
V.A. Benefits	___________________________
Aid to Families with Dependent Children (AFDC)	___________________________
Supplemental Security Income (SSI)	___________________________
Rental Income	___________________________
Other	___________________________
Total Monthly Income	___________________________

Verification of income is required. You must supply the Business Office with a copy of your last 2 years 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.

(Please complete next page)

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

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

____

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					
Other Creditors (please list)					

(Please complete next page)

Type	Monthly Amt	Remaining Balance
Medical Debt.		
Facility		
Doctor(s) name		
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		