JACKSON COUNTY REGIONAL HEALTH CENTER
700 WEST GROVE STREET
MAQUOKETA, IA 52060
(563) 652-2474

DATE:________________ RETURN BY:_________________

Dear Applicant for Financial Assistance:

Attached is the application form for Financial Assistance that you requested. Please fill out ALL areas on the form to the best of your ability. If you need assistance completing this application, please call our Business Office from 8:00 a.m. to 4:30 p.m., Monday through Friday and ask to speak to one of our representatives.

YOU MUST APPLY WITH D.H.S. TO TRY AND QUALIFY FOR ASSISTANCE FIRST. IF IN FACT YOU ARE DENIED, THAT LETTER MUST BE ATTACHED TO THE FOLLOWING INFORMATION.

You will **NEED** to return the following information to us:

1. Completed application for Financial Assistance. Be sure to attach a separate sheet listing other circumstances you feel should be considered during the review of your application.
2. PROOF OF INCOME
   a. Last year's Income Tax Return-Federal and State and a copy of applicable schedules attached such as schedule F, SE, etc. Be sure and copy last year's W2 also.
   b. Include the past two months of payroll check stubs for yourself and/or spouse, if working.
   c. Verification of wage from any Public Assistance Agencies.
3. An itemization of all expenses:
   a. Cost of shelter
   b. Cost of food
   c. Cost of utilities
   d. Cost of transportation
   e. Any other monthly expenses i.e. doctor bills, telephone, car payments, etc.

*Failure to send all requested information will result in a denial of your application and the full balance(s) of your account(s) will be due and payable within 30 days. If payment arrangements need to be made, please feel free to contact the Business Office at
(563) 652-2474 to do so.

Thank you,
Business Office

JACKSON COUNTY REGIONAL HEALTH CENTER
MAQUOKETA, IA

APPLICATION FOR FINANCIAL ASSISTANCE

Applicant Name____
First Middle Last

Address____
Number & Street City State Zip

Telephone: (__________) _____________________Cellular (______)______________

Please circle appropriate item: Buying home Buying mobile home Renting house
Renting apartment Living with relatives Other

How long have you lived at this address? __________Years____________Months

Patient Name______________________Date(s) of Service____________________________

Family Size: Number of Adults ______________Number of Children__________Total________

EMPLOYMENT: ENTER ALL EMPLOYMENT DURING THE PAST YEAR FOR EACH FAMILY MEMBER:

WORKERS NAME	NAME OF EMPLOYER	DATE OF EMPLOYMENT	GROSS INCOME LAST 12 MONTHS	GROSS INCOME LAST 3 MONTHS

YOU MUST ATTACH INCOME TAX RETURNS AND W-2'S TO THIS FORM!

OTHER SOURCES OF INCOME:

SOURCE OF INCOME	DATES INCOME RECEIVED	GROSS INCOME LAST 12 MONTHS	GROSS INCOME LAST 3 MONTHS
Self-Employment			
Workmans Compensation			
Social Security			
Social Security (Spouse)			
Social Security Disability(SSI)			
Child Support/Alimony			
Veterans Benefit			
Railroad Retirement Benefits			
Disability Insurance Payment			
Income on Stocks, Bonds, Annuities, Other Investments			
Personal Injury Insurance Settlement			
Cash from Relatives			
Public and/or General Assistance			
Tax Refunds			
Business/Personal Loans for Income			
Gross Business Income			
Gross Farm Income (Sale of Commodities/Livestock)			
Interest Income			
Unemployment Compensation			

CASH

CASH ASSETS	AMOUNT	NAME OF COMPANY/SOURCE
CASH ON HAND		
CHECKING ACCOUNT		
SAVINGS ACCOUNT		
MARKET VALUE OF STOCKS, BONDS, ANNUITIES, OTHER INVESTMENTS		
TRUST FUND		
LIVE INSURANCE CASH VALUE		
TIME CERTIFICATES		

PERSONAL PROPERTY/REAL/BUSINESS

DESCRIPTIONS	DESCRIPTION	MARKET VALUE	AMOUNT OWED
Automobile/Truck			
Automobile/Truck			
Automobile/Truck			
Motorcycle/Moped			
Farm Equipment			
Snowmobile			
Boats/Motors/Trailers			
Mobile Home/Campers			
Recreational Vehicle			
Livestock			
Stored Grain			
Business Property			
Farm Land/Buildings			
Residential Property			
Other Rental/Income			

I UNDERSTAND THAT THE INFORMATION SUBMITTED CONCERNING ANNUAL INCOME/ASSETS AND FAMILY SIZE IS SUBJECT TO VERIFICATION.

I ALSO UNDERSTAND THAT INFORMATION SUBMITTED ON THIS FINANCIAL ASSISTANCE APPLICATION WHICH IS FALSE OR MISLEADING WILL RESULT IN A DENIAL OF THE REQUEST.

DATE OF APPLICATION____________________

SIGNATURE____

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FOR HOSPITAL USE ONLY

Date Application Issued:__________________Date Returned:__________________________

Revised 11/2/2007

JACKSON COUNTY REGIONAL HEALTH CENTER
CONFIDENTIAL FINANCIAL DATA
(Information provided is kept strictly confidential)

DATE TO CLIENT_________________RETURN TO JCRHC BY___________________

Please complete this form and return to the JCRHC Business Office as soon as possible. If this form is not returned to our office by the date indicated above, we shall assume you wish to pay in full and you will be billed accordingly.

NAME________________________________SOC. SEC#________________________

ADDRESS____

CHOOSE ONE OF THE FOLLOWING: 1 OR 2

1:
I **DO NOT** WISH TO DISCLOSE MY INCOME AND AGREE TO PAY IN FULL.
DATE______________________SIGNATURE________________________________

2:
IF YOU CHOOSE TO DISCLOSE YOUR INCOME INFORMATION:

YOU MUST COMPLETE THE FOLLOWING:

LIST OTHERS LIVING IN YOUR HOUSEHOLD:

NAME	RELATIONSHIP

ARE YOU CLAIMED ON ANYONE ELSES TAX FORM? ____YES ____NO

DO YOU OWN PROPERTY OTHER THAN WHERE YOU RESIDE? ___YES ___NO

******PLEASE ATTACH A STATEMENT OF YOUR MONTHLY EXPENSES******

A COPY OF YOUR FEDERAL AND STATE TAX FORMS, AND ALL ATTACHMENTS MUST BE SUBMITTED WITH THIS FINANCIAL DATA.

_______I AM NOT RETURNING THE ABOVE FORMS.

JACKSON COUNTY REGIONAL HEALTH CENTER
CONFIDENTIAL FINANCIAL DATA
(Information provided is kept strictly confidential)

Please provide the name, address, and phone numbers of **EACH** and **EVERY** bank or financial institution you utilize or have utilized within the past year.

NAME	COMPLETE ADDRESS	PHONE

I__________________________, authorize and give permission to the above named bank, financial institution, or entity, to provide any financial information to the Jackson County Regional Health Center, and in signing this release, I agree to release and hold such bank, financial institution, or entity harmless from any liability for the release of such information to the Jackson County Regional Health Center. A photocopy of this release may be given the same full force and effect as the original release.

_______________________________________ SIGNATURE

___________________________ DATE