HAWARDEN REGIONAL HEALTHCARE
1111 11th Street Hawarden, Iowa 51023
Phone (712) 551-3100 Fax (712) 551-3195

FINANCIAL ASSISTANCE APPLICATION

In order to offer a reduced balance, and/or charity allowances, Hawarden Community Hospital must substantiate your financial need. Please complete this application and return a copy of your most recent tax return, your last pay stub showing wages earned, 2 recent bank statements and a Medicaid denial

APPLICANT INFORMATION

Name:_____ Sex:_____Male _____Female
Address:_____City/State?Zip:_____
Phone*:_____Date of Birth:_____Social Security #:_____
Marital Status:_____Single _____Married _____Divorced _____Widowed _____Seperated
If Married: Spouse Name:_____Social Security #:_____

Dependents

I am responsible for support of the following individuals (include spouse)

Name	Birth Date	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT

	Self	Spouse
Name of Employer:	_____	_____
Employer Address:	_____	_____
Employers Phone:	_____	_____
Length of Employment	_____Years _____Months	_____Years _____Months
Occupation	_____	_____

If not employed are you? Retired Unemployed Not in Labor Force (circle one)

BANKING INFORAMTION

Bank Name:_____
Address:_____City/State?Zip:_____
Checking Account Balance:_____ Savings Account Balance_____
Do you have other investments / securities? ___Yes ___No If yes, what is balance?_____

PROPERTY/OTHER ASSETS

	Estimated Value	Unpaid Balance
Mortgage:_____	$_____	$_____
Vehicles:_____	$_____	$_____
_____	$_____	$_____
Other Property_____	$_____	$_____
	$_____	$_____
	$_____	$_____

OTHER

Other information that you feel is important_____
_____

_____
_____

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MONTHLY INCOME

	Self	Spouse
Employment (gross pay):	$_____	$_____
Part-time Jobs:	$_____	$_____
Social Security:	$_____	$_____
Pensions:	$_____	$_____
Unemployment:	$_____	$_____
Work Compensation	$_____	$_____
Union Benefits	$_____	$_____
Investment Income	$_____	$_____
Rentals:	$_____	$_____
Child Support:	$_____	$_____
Food Stamps:	$_____	$_____
ADS:	$_____	$_____
Welfare:	$_____	$_____
Other: Monetary gifts, alimony, etc:	$_____	$_____
TOTAL MONTH INCOME	$_____	$_____

VERIFICATION/AUTHORIZATION

I HAVE APPLIED FOR Title XIX benefits: _____Yes _____No Outcome_____
I have applied for Social Security benefits: _____Yes _____No Outcome_____
I have applied for Disabiltiy benefits: _____Yes _____No Outcome_____

I certify that all inforatmion listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services provided by Hawarden Community Hospital and Clinic.

I hereby grant permission to Hawardent Community Hospital and Clinic to verify information contained herein.

_____ _____
Applicant's Signature Date