MONROE COUNTY HOSPITAL & CLINICS
UNCOMPENSATED CARE APPLICATION

As provided in the Monroe County Hospital & Clinics Financial Assistance Policy, I hereby request consideration of my eligibility to receive reduced or free care at Monroe County Hospital & Clinics. I understand that the information I submit regarding income, asset holdings, and household sizes are all subject to verification by Monroe County Hospital & Clinics. I also understand that the falsification of any information automatically results in a denial of reduced or free care and that I am liable for all charges for services received at Monroe County Hospital & Clinics.

FILLING OUT THIS APPLICATION IS NOT A GUARANTEE OF ACCEPTANCE

1. Patient Information

Name ____ ________________
(Last) (First) (MI) (Telephone Number)

Address____
(Street) (City) (State) (Zip Code)

Birth Date ___________Age___________Social Security Number ____________________

Marital Status ____

2. Person financially responsible for patient (Complete if Responsible Party is other than Patient)

Name ____ ________________
(Last) (First) (MI) (Telephone Number)

Address ____
(Street) (City) (State) (Zip Code)
Birth Date ____________Age___________Social Security Number ____________________

Marital Status ____

2a. If person financially responsible for patient is currently employed, complete this section.

Name and Address of First Employer

____ ______________
(Name of Employer) (Telephone Number)

Address ____
(Street) (City) (State) (Zip Code)

Job Title ______________________________ Number of hours worked weekly__________

Gross Earnings: Hourly Rate $_____________Weekly $_____________Annual $____________

3. Second Employer (Complete if you have 2 employers or use for employer of spouse of financially responsible person)

(Name of Employer) ________________________________ (Telephone Number) ___________

Address ____
(Street) (City) (State) (Zip Code)

Job Title __________________________________ Number of hours worked weekly ______

Gross Earnings: Hourly Rate $__________________Weekly $____________Annual $ _____________

4. LIST ALL OTHER PERSONS LIVING IN THE HOUSEHOLD
Household members (living with you, who you are responsible for and/or who you are living with).

Name	Relationship

5. OTHER SOURCES OF INCOME:
All household members(living with you, who you are responsible for and/or who you are living with).

Source of Income	Circle One	Amount Received	How Often?	Name(s) of Recipient(s)
Social Security/SSI	Yes No			
Child Support/Alimony	Yes No			
Pension/Compensation	Yes No			
Interest/Dividend	Yes No			
Trusts/Estates	Yes No			
Other (explain)	Yes No			

6. FINANCIAL RESOURCES OTHER ASSETS AND LIABILITIES
All household members (living with you, who you are responsible for and/or who you are living with).

Line	Item	Amount	Description
1	Checking Account		
2	Savings Account		
3	Investments (non-retirement)		
4	Automobiles		
5	Primary Residence		
6	Other Property		
7	Home Mortgage		
8	Hospital Balances		
9	Credit Card Balances		
10	Other Debts Owed		

Monthly Expenses

If no income reported: Please provide how you pay for: Rent, Utilities, Transportation, Food, Personal items, Household supplies, Basic living expenses.

ITEM	Dollar Amount
Automobile Payment(s)	
Automobile Insurance Payment	
Mortgage Payment	
Rent Payment	
Medications	

7.OTHER COMMENTS OR SPECIAL CIRCUMSTANCES THAT WARRANT FURTHER CONSIDERATION:

8. DO YOU HAVE ANY FORM OF THIRD-PARTY COVERAGE FOR HEALTH CARE EXPENSES, EITHER PRIVATE OR PUBLIC, AT OUR FACILITY, OR ANY OTHER HEALTH CARE FACILITY? IF YES, PLEASE SPECIFY THE COVERAGE THAT IS AVAILABLE FOR YOUR MEDICAL CARE.

PLEASE ATTACH COMPLETE COPIES OF ALL HOUSEHOLD MEMBERS LATEST FILED FEDERAL INCOME TAX RETURN WITH ALL SUPPORTING SCHEDULES, AND A COPY OF YOUR MOST RECENT PAY STUB(S). WE CANNOT PROCESS THIS APPLICATION UNLESS ACCOMPANIED BY THIS INFORMATION.

This application will be reviewed by designated staff and remain confidential. Results of the review will be used only by our billing staff and our business affiliates.

I hereby certify that the answers given on my application are true to the best of my knowledge. I further understand that any false or misleading claims, statements, documents or concealment of a material fact may result in the immediate cancellation of any agreement terms made previously.

Return completed form to: Monroe County Hospital & Clinics | 6580 165th St. | Albia, IA 52531

SIGNATURE: ____ DATE: ____

(Patient or person financially responsible for patient)