

**HEGG MEMORIAL HEALTH CENTER
APPLICATION FOR FINANCIAL ASSISTANCE**

Dear Patient,

Thank you for choosing Hegg Memorial Health Center for your health care needs. We are committed to improving the health and well being of everyone in our community. We are pleased to offer our financial assistance and charity care program to help individuals and families who need assistance.

Enclosed is our Financial Assessment form. Please return the completed form with the requested documents by: _____. If you have questions about the documents or do not have all the documents, please contact the Financial Counselor at the phone number below. We will gladly assist you. Thank you for your cooperation.

Applicants will need to provide:

- A copy of your most current **Federal Income Tax Return**. Include all schedules and pages. If you do not file a tax return, please explain why. If you need copy of your tax return, you can call the Internal Revenue Service (IRS) at 1-800-829-1040.
- A copy of the most recent **pay check stub** for all members of your household.
- A copy of the most recent **bank statement** for all accounts.

If these documents are not available, please explain why in the section of the Patient Financial Statement provided for documentation.

For the Patient Financial Statement, Members of Household are defined as follows:

- If the patient is an adult include the patient, the patient's spouse and any dependents.
- If the patient is a minor, include the patient, the patient's father, dependents of the father, the patient's mother, and dependents of the mother.
- "Dependents" is defined in accordance with IRS guidelines.

For the Patient Financial Statement, income represents cash receipts before taxes and includes but is not limited to, wages, salaries, tips, interest, dividends, taxable refunds, credits or offsets of state and local income taxes, alimony received, business income/loss, capital gains/loss, IRA distributions, pensions, and annuities; income from rental real estate, royalties, partnerships, corporations, and trusts, farm income/loss, unemployment compensation, social security benefits, VA benefits, workman's compensation, and disability.

Please submit the requested documents to: **Hegg Memorial Health Center**
Attn: Lori Eppinga
1202 21st Ave
Rock Valley, IA 51247
Ph. # 712-476-8005

Completion of this form is not a guarantee of eligibility of Financial Assistance/Charity Care, or any other program. Financial Assistance/Charity Care is only considered after all possible sources of coverage or potential payment (for example, health insurance, Medicare, Medicaid) have been exhausted. Failure to provide all requested documents before the deadline date above will result in non-approval.

Thank you,

Financial Assistance Counselor

PATIENT FINANCIAL STATEMENT

Guarantor/Responsible Party Name (full legal name)	
Patient Name (if other than responsible Party)	Patient Account Number
Address (city, state, zip code)	Phone Number
Spouse Name	Phone Number

Employer Information

<input type="checkbox"/> Guarantor <input type="checkbox"/> Patient <input type="checkbox"/> Spouse	<input type="checkbox"/> Guarantor <input type="checkbox"/> Patient <input type="checkbox"/> Spouse
Employer: Name	Employer: Name
Address	Address
Phone #	Phone #
Job Title	Job Title
Length of Employment	Length of Employment

Members of Household: Please refer to cover letter to determine members of household.

NAME	Date of Birth	Relationship to you

Income: Please refer to cover letter to determine income.

Source of Income	Household Member	Amount Received	W-Weekly B-Biweekly M- Monthly A-Annually

Banking and Investments: Include all bank accounts, savings accounts, retirement accounts (IRA, Pension Fund, 401k, 403b, etc), money markets, mutual funds etc.

Banking /Investments	Amount	Comments

Other Assets: Includes real or personal property EXCEPT patient home (primary residence) and personal vehicles. Examples of assets to include are rental property, vacant lots, farm acreage, business property, vacation property, boats, motor homes, all terrain vehicles, etc.

Property	Estimated Value	Amount Owed on Property	Net Value

Please itemize your outstanding medical expenses, and if known, indicate the amount still owed after insurance company pays. Please attach copy of bills.

Name of Provider (Hospital/Physician/Pharmacy)	Balance Due
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
TOTALS	\$

This Patient Financial Statement should be signed and dated by all applicable parties in order to process your application.

I represent that the information provided is true and accurate to the best of my knowledge. Hegg Memorial Health Center is hereby authorized to obtain a credit report in connection with the social security number which I, as payor and signer of this form, certify to be my legally assigned individual social security number.

Signature of Patient of Responsible Party Social Security Number Date

I represent that the information provided is true and accurate to the best of my knowledge. Hegg Memorial Health Center is hereby authorized to obtain a credit report in connection with the social security number which I, as payor and signer of this form, certify to be my legally assigned individual social security number.

Signature of Spouse Social Security Number Date