FINANCIAL ASSISTANCE APPLICATION

Davis County Hospital knows there are times when our patients cannot pay for the services provided. If you need help paying for medical services, you may be eligible for Financial Assistance from Davis County Hospital.

To see if you qualify, please follow the instructions below.

Be sure to give full information for everyone within your tax filing household. If you don't return complete information with supporting documents your request cannot be processed. All information will be kept private.

Important Notes

In order to assure that all resources for payment are exhausted prior to the Financial Assistance from Davis County Hospital, a patient must first apply for State Assistance through the Department of Human Services Medicaid. Our Financial Counselor is available to help you find out if you qualify for other Federal or State Assistance Programs.

Financial Assistance is only available for medically necessary services provided by Davis County Hospital, Davis County Medical Associates and Specialty Physicians that billing is completed by the Patient Financial Services Department at Davis County Hospital.

If you have more questions about your bill, please call 641-664-2145. To speak with the Financial Counselor please call 641-664-7144.

Documentation Needed to Apply.

1. Financial Assistance Application
2. Bank Statement for the previous 3 months.
3. Copy of DHS Notice of Decision for Medicaid.
4. Tax Return for previous year, if filed.
5. Proof of Income for everyone in your tax filing household.

   Send Copies of all items listed below that **apply.**

   - If you are employed: last 3 months of pay stubs
   - If you are self-employed: balance sheet and income statement
   - If you are unemployed: state unemployment claim and final pay stub from last job.
   - Monthly pension amount letter
   - Disability income amount letter
   - Social Security income amount letter
   - Proof of income from rent
   - Proof of income from alimony
   - If you have NO income, written statement from person who supports you.

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1. Members of Tax Filing Household:

Name	Relationship	Date of Birth	Sex
	Self		

2. Address/Phone/E Mail

Street Address	City	County	State	Zip

Home Phone	Cell Phone	E Mail Address

3. Applicant's Current Job and Income Information:

Current Job 1:

Employer name and address	Employer phone number
Wages and tips (before taxes) $ Hourly / Weekly / Bi-Weekly /Twice a Month /Monthly	Average hours worked each week:

Current Job 2:

Employer name and address	Employer phone number
Wages and tips (before taxes) $ Hourly / Weekly / Bi-Weekly /Twice a Month /Monthly	Average hours worked each week:

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Self-Employment:

Type of work _____

How much gross income will you get from this self-employment this month? $_____

Other Income This Month: Check all that apply, and give the amount and how often you get it.

☐	None		How Often?
☐	Unemployment	$_____	_____
☐	Pensions	$_____	_____
☐	Social Security	$_____	_____
☐	Retirement accounts	$_____	_____
☐	Alimony received	$_____	_____
☐	Rental/royalty	$_____	_____
☐	Other	$_____	_____ Type _____

Spouse/Significant Other Job and Income Information:

Current Job 1:

Employer name and address	Employer phone number
Wages and tips (before taxes) $ Hourly / Weekly / Bi-Weekly /Twice a Month /Monthly	Average hours worked each week:

Current Job 2:

Employer name and address	Employer phone number
Wages and tips (before taxes) $ Hourly / Weekly / Bi-Weekly /Twice a Month /Monthly	Average hours worked each week:

Self-Employment:

Type of work _____

How much gross income will you get from this self-employment this month? $_____

Other Income This Month: Check all that apply, and give the amount and how often you get it.

☐	None		How Often?
☐	Unemployment	$_____	_____
☐	Pensions	$_____	_____
☐	Social Security	$_____	_____
☐	Retirement accounts	$_____	_____
☐	Alimony received	$_____	_____
☐	Rental/royalty	$_____	_____
☐	Other	$_____	_____ Type _____

CERTIFICATION STATEMENT

Note: Read carefully before signing.

I understand that I assume full responsibility for the accuracy of the statements on this form, and I understand that Davis County Hospital will use these statements to determine my eligibility for the Financial Assistance Program. If any information changes, it is my responsibility to contact Davis County Hospital to report such changes. I further understand that any false representations or false claims, statements, or documents or concealment of a material fact may result in the immediate termination of any financial assistance granted to me or my family and that I will be liable to repay all amounts of financial assistance previously provided to me.

I understand that Davis County Hospital may contact other agencies including Davis County Department of Human Services to confirm statements made in this application and to obtain information that may be necessary to establish my eligibility for the Financial Assistance Program. My signature below shall authorize such mutual exchange of information between Davis County Hospital and appropriate agencies or persons.

I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. **(Each adult listed on this application must sign)**

_____ _____
Signature of Applicant (or legal guardian) Date

_____ _____
Signature of Spouse or Significant Other (if applicable) Date

PROHIBITION AGAINST DISCRIMINATION

We will consider this application without regard to race, color, sex, age, handicap, religion, national origin, or political belief.

RIGHT OF APPEAL

If you are not satisfied with the action of this office, you may appeal to the Chief Executive Officer of Davis County Hospital, 509 N. Madison St., Bloomfield, IA 52537. (641) 664-7080