To assist Pocahontas Community Hospital in the determination of your eligibility for possible assistance, the following information must be completed in full. If you would like assistance in completing the application, please contact Pocahontas Community Hospital office at 712-335-3501. Return the completed application along with the required documentation to the Business Office.

CONFIDENTIAL

Pocahontas Community Hospital

606 NW 7th St

Pocahontas, Iowa 50574

712-335-3501

Application for Financial Assistance

Required documents:

- Most recent tax return.
- Proof of income for the months of _____, _____ ,_____.
- Current Public Assistance denial for medical assistance from your local office of the Department of Human Services.

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Social Security Number: _____

Home Address: _____ City, State, Zip_____

Phone number _____

How long have you lived at your current address? _____

Do you (circle one) own your home rent your home live with family/friends

Spouse/Dependents

Name	Age	Relationship

Monthly Family Income/Assets

Employer's Name:_____ Spouse's Employer's Name: _____

Occupation: _____ Spouse's Occupation: _____

How long at current employer? _____ How long at current employer? _____

Salary: (Gross) _____ week/month Spouse's Salary: (Gross) _____ week/month

If less than 3 months, list previous employer for past three months:

Who was employed	Employer Name	Length of time at employment

Other sources of income

Social Security	$	Railroad retirement	$
Unemployment	$	Workmen's Compensation	$
Retirement income	$	Child Support	$
Alimony	$	Public Assistance	$
Dividends,interest	$	Rent	$
Unemployment compensation	$	Other (specify)	$
Other (specify)	$	Other (specify)	$

Resources	Amount	As of Date	Location
Cash on hand			
Checking Account			
Savings Account			
Stocks/Bonds/securities (cash value)			
Other Resources			
Other Resources			
Total	$		

Property	Year/Make/Model	Estimated Value	Unpaid Balance
Home			
Automobile			
Automobile			
Recreational Vehicle			
Other			
Total		$	$

Monthly Expenses

Rent/mortgage $	Medical Insurance $
Utilities; gas/electric/water	Automobiles payments
Property Taxes	Automobile Insurance
Food	Cable TV
Telephone	Bank loans
Credit Cards	Clothing
Child-Care	Other (please specify)
Other (please specify)	Other (please specify)

If needed, please feel free to use an additional sheet of paper to list all loans, credit cards, medical expenses, etc.

Has an application been completed for the following Government Assistance Programs?

Program Yes/No Approved / Denied Name of Recipient $ Amount

Disability/ SSI _____

Title TXIX _____

Medically Needy _____

General Relief _____

Food Stamps _____

Utility Assistance _____

Other (please specify) _____

If you are not aware of this assistance, contact your local Social Service Department or Department of Human Service's for more information.

If there are extenuating circumstances that would be helpful to us in understanding your need for financial assistance, please use the space below to explain.

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I/We hereby certify that I/We are of legal age and that the foregoing statements are true and complete and are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this application shall remain the property of Pocahontas Community Hospital, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income. I/We authorize the verification of any reported information on this application by Pocahontas Community Hospital.

_____ _____

Signature of Applicant Date

Return to: Pocahontas Community Hospital,
Business Office
606 NW 7th St
Pocahontas, Iowa 50574

Pocahontas Community Hospital will review the information you have provided and you will receive written notification of decision.

Determination:
{ } Full Financial Assistance
{ } Partial Financial Assistance
{ } No Financial Assistance Granted

_____ _____

Date Signed

Pocahontas Community Hospital
606 NW 7th St.
Pocahontas, Iowa 50574
712-335-3501

Request for Financial Assistance

Pocahontas Community Hospital is committed to providing necessary hospital care and treatment to the indigent. Any patient who has received services and who falls below certain income and asset limits may be eligible for hospital care free of charge, or at a reduction in our established charges.

The Hospital uses the poverty income guidelines issued by Health and Human Services (as well as a pre-determined asset limit) as a basis for eligibility criteria for indigent care. These guidelines are adjusted annually, based on increases in the consumer price index. Support to grant financial assistance must be fully documented in our files.

The Guidelines listed below shall be used to implement this policy and to fulfill our responsibility for adequate documentation.

1. Application forms will be given to patients upon request only.

2. The applicant must exhaust all other sources of financial assistance or entitlement before the application can be processed.

3. An "Application for Financial Assistance" form must be filled out completely, dated and signed by the party responsible for payment of the bill.

4. Failure to supply all forms properly completed an/or other forms as requested will void the original request for financial assistance.

5. The Hospital may make special concession to responsible parties who may be over the income guidelines but have extenuating medically related circumstances.

6. The Hospital reserves the right to review the financial agreement any time it may have reason to believe the patient and/or responsible party's financial situation has changed significantly. Failure to supply requested information for review may change the agreement on the account back to full bill at the established rate.

7. A separate application must be completed for each spell of illness.