Buchanan County Health Center

Here for you. Trusted for life.

Finance
1600 First Street East
Independence, IA 50644
Office: (319) 332-0999
www.bchealth.info

Application for Financial Assistance

In recognition of Buchanan County Health Center's policy to provide quality health care to all persons regardless of their financial status, the financial assistance program provides assistance to those in need in a fair, non-discriminatory manner.

Financial Assistance Instructions:

1. A completed application must be returned to the hospital for consideration within 30 days of issue. Financial Assistance is only available for BCHC hospital services.
2. To be eligible for financial assistance, each applicant must meet minimum gross income requirements set by the Federal Government along with cash and asset requirements.
3. Buchanan County Health Center reserves the right to request verification of income. Refusal of an applicant to provide any requested information may result in denial of financial assistance.
4. Buchanan County Health Center will submit a response to the applicant within 14 working days of the receipt of a completed application and supporting information.
5. Only ONE financial assistance determination will be made per account.
6. Financial assistance applicants will be responsible for paying the balance remaining on an account after any assistance has been granted WITHIN 60 DAYS. Failure to pay the remaining balance may cancel any assistance granted on the account. Payment arrangements may be extended due to special situations.
7. Complete all the questions on the application for financial assistance.
8. Enter employment information for both husband and wife. If unemployed enter "unemployed" under employer, indicate date of unemployment under employment date and indicate current monthly gross income.
9. Other income sources should include income from self-employed business ownership, farm and any other income received.
10. Complete cash assets section for both husband and wife.
11. Both husband and wife must sign and date the application.
12. Please submit the following information along with your application. Financial assistance cannot be provided without the requested information:
    a. _____ Copy of your most recent paycheck stub/voucher
    b. _____ Verification of monthly income from Social Security if applicable
    c. _____ Verification of unemployment income if applicable
    d. _____ Copy of your _____ calendar year signed Federal Tax Return
    e. _____ Copy of last month's complete bank checking and savings statements

If you have any questions call the Health Center's business office at 319-332-0999.

Buchanan County
HEALTH CENTER

APPLICATION FOR FINANCIAL ASSISTANCE

RESET PAGE

For Office Use Only *Date Issued:* _____ *Date Received:* _____

Patient Account Number(s): _____

Date of Service: _____ Name of Patient: _____

APPLICANT INFORMATION:

Applicant Name: _____ / _____ / _____
First *Middle* *Last*

Applicant Birthdate: _____ / _____ / _____ Applicant Social Security Number _____ - _____ - _____

Address: _____ _____ _____ _____
Number and Street *City* *State* *Zip*

Telephone Number: ( ) _____ Cell Phone Number: ( ) _____

Spouse Name: _____ / _____ / _____
First *Middle* *Last*

Spouse Birthdate: _____ / _____ / _____ Spouse Social Security Number _____ - _____ - _____

Residence: ☐ Own ☐ Rent ☐ Reside With Family Member ☐ Other: _____

Amount of Rent / Mortgage: $_____

Are you a United States Veteran? ☐ Yes ☐ No Are you required to file a tax return? ☐ Yes ☐ No

Is your spouse? ☐ Yes ☐ No Is your spouse? ☐ Yes ☐ No

DEPENDENT INFORMATION:

Number of Adults: _____ Number of Children: _____

Names and Ages of Children: _____

EMPLOYMENT INFORMATION:

First Name	Employer	Length of Employment	Full Time	Part Time	Pay Period: Weekly, Monthly Bi-Monthly, etc.	Hours Worked Per Pay Period	Hourly Pay

OTHER INCOME SOURCES:

Sources	Applicant	Spouse	Total Amount Received
Unemployment Benefits			
Disability Benefits			
Social Security Benefits			
Child Support			
Alimony			
Interest Income			
Pension Benefits			

ASSETS:

Financial Institution	Names on Account	Checking Account Number	Checking Account Balance	Savings Account Number	Savings Account Balance

OTHER ASSETS:

Assets	Applicant	Spouse	Cash Value
Stocks / Bonds / C.D.			
Life Insurance			
401k / Retirement Savings Plan			

Comments: _____

I certify that all information 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. I hereby grant permission to Buchanan County Health Center to investigate the information contained herein.

Applicant Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

Send completed application to: Business Office
Buchanan County Health Center
1600 First Street
Independence, Iowa 50644

For Office Use Only:
Approval Percentage: _____

Approved by: _____ Date: _____