

FINANCIAL ASSISTANCE APPLICATION

As provided for in Federal law, I hereby request that Regional Medical Center (RMC) make a written determination of my eligibility for uncompensated services at RMC. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by RMC, and I authorize release of information upon their request. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services rendered.

Complete this application and send to RMC with the following

- Copy of page from last year's income tax return showing the "adjusted gross income"
- Copy of last three months of paycheck stubs
- Copies of any unpaid or recently paid medical bills from other facilities

Please Send To:
Regional Medical
Center
FAP Clerk
PO Box 359

Date of Application / /

Applicant				
Name				
Date of Birth				
Present Address				
City		St		Zip
Home Phone				
Cell Phone				
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried				
Employer				

Spouse or Significant Other (living in same household)				
Name				
Date of Birth				
Present Address				
City		St		Zip
Home Phone				
Cell Phone				
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Unmarried				
If unmarried, does the couple share expenses? <input type="checkbox"/> Y <input type="checkbox"/> N				
Employer				

Number of Dependents

List dependents under the age of 18

Name	Date of Birth	Relationship

Name	Date of Birth	Relationship

Income Verification: If employed outside of home, provide proof of income for the last three months

Other source of income	Yes or No	Amount	How often is income received?	Name or name(s) of person(s) receiving
AFDC Aid for Dependent Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Worker's Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Social Security (SS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Veteran's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Child Support	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Disability Insurance Payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Money from Interest, Dividends	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Retirement Plan Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Health Savings Accounts	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Other (explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

Income tax return was filed last year Yes No

Have you applied for RMC's Financial Assistance in the last 12 months?

Yes No If yes, approximate date of application / /

Balances from prior applications will not be adjusted.

Questions
563-927-7587
regmedctr.org/FAP

I hereby acknowledge that the above information, given to RMC is true and correct; and I hereby authorize RMC or their agent to verify any information on this form.

Applicant Signature

Date