FINANCIAL ASSISTANCE APPLICATION

Este formulario está disponible en Español a petición

Regional Medical Center

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

- **Proof of determination of eligibility from Medicaid, please contact DHS at 800-642-6609 to request an application or apply online at http://dhs.iowa.gov/how-to-apply.**
- 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	☐Married ☐Separated ☐ 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	☐Married ☐Separated ☐ Unmarried				
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	☐Yes ☐No	$		
Worker's Compensation	☐Yes ☐No	$		
Social Security (SS)	☐Yes ☐No	$		
Veteran's Benefits	☐Yes ☐No	$		
Child Support	☐Yes ☐No	$		
Alimony	☐Yes ☐No	$		
Disability Insurance Payments	☐Yes ☐No	$		
Money from Interest, Dividends	☐Yes ☐No	$		
Unemployment	☐Yes ☐No	$		
Retirement Plan Income	☐Yes ☐No	$		
Health Savings Accounts	☐Yes ☐No	$		
Rental Income	☐Yes ☐No	$		
Other (explain)	☐Yes ☐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 _____