FINANCIAL ASSISTANCE APPLICATION

Regional Medical Center

It is the policy of Regional Medical Center to provide essential services regardless of the patient's ability to pay. Regional Medical Center offers discounts based on family size and annual income. 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.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" (as requested)
- Copy of last three months of paycheck stubs (as requested)
- Copies of any unpaid or recently paid medical bills from other facilities (as requested)

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:			
Employer					

Spouse or Significant Other (living in same household)					
Name					
Date of Birth					
Present Address					
City		St		Zip	
Home Phone:		Cell Phone:			
If unmarried, does the couple share expenses? ☐Y ☐N					
Employer					

Number of Dependents		*** List dependents under the age of 18 below**

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
563-927-7405
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 _____