# Financial Assistance Application

**Section 1: Patient and Guarantor Information**

Patient Name: ________________________________ Date of Birth: _____ /_____ /_____ Marital Status ________

Guarantor Name (if patient is a minor) ___________________________ Contact Phone Number __________________

Address _________________________________ City: _______________________ State: _____ Zip Code: _________

| Name(s) of **Spouse** and additional dependents (Use additional page if you need more room) | Date of Birth | Relation to Patient |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**Section 2: Insurance Information**

Name(s) of your insurance company: ____________________________________________________________________

**Section 3: Income Information**

| Source of Income | Gross Income for Prior 12 Months | Gross Income for Prior 12 Months for Spouse or Other Household Member(s) | Please include the most recent copy of the items below |
|---|---|---|---|
| Wages □<br>Self Employed □ | | | Last three pay stubs<br>Most recent tax return |
| Social Security □ | | | Social Security benefit letter |
| Pension/Disability □<br>Rental Income □ | | | Pension/Disability letter<br>Most recent tax return |
| Unemployment □<br>Workers' Compensation □ | | | Unemployment letter<br>Worker's Compensation letter |

Line A: If you have $0 income, please provide your last date of employment and tell us how you meet basic living needs:

______________________________________________________________________________________________

By signing this form, I agree that:

- The information in this form is correct. It is against the law to give false information.
- JCHC may confirm the information in this form.
- I am a current legal resident of the state of Iowa.

Patient/Guarantor's signature ____________________________________________ Date ____________________

** Your application will not be processed if there is incomplete or missing information **

## Jefferson County Health Center Charity Care Guidelines

| SIZE OF FAMILY UNIT | 100% CHARITY | 90% CHARITY | 60% CHARITY | 40% CHARITY | 20% CHARITY | 10% CHARITY | 0% CHARITY |
|---|---|---|---|---|---|---|---|
| 1 | $12,880 | $19,320 | $25,760 | $32,200 | $38,640 | $45,080 | >$45,080 |
| 2 | $17,420 | $26,130 | $34,840 | $43,550 | $52,260 | $60,970 | >$60,970 |
| 3 | $21,960 | $32,940 | $43,920 | $54,900 | $65,880 | $76,860 | >$76,860 |
| 4 | $26,500 | $39,750 | $53,000 | $66,250 | $79,500 | $92,750 | >$92,750 |
| 5 | $31,040 | $46,560 | $62,080 | $77,600 | $93,120 | $108,640 | >$108,640 |
| 6 | $35,580 | $53,370 | $71,160 | $88,950 | $106,740 | $124,530 | >$124,530 |
| 7 | $40,120 | $60,180 | $80,240 | $100,300 | $120,360 | $140,420 | >$140,420 |
| 8 | $44,660 | $66,990 | $89,320 | $111,650 | $133,980 | $156,310 | >$156,310 |
| | | | | | | | |
| For each additional person | $4,540 | $6,810 | $9,080 | $11,350 | $13,620 | $15,890 | >$15,890 |

Once you qualify for our assistance, your application will be good for (6) months, at which time you will need to resubmit a new application with current financial information.

**DEFINITIONS:**

**FAMILY** means one or more adults and children, if any, related by blood, or law and residing in the same household. Where adults, other than spouses, reside together, each may be considered a separate family. Emancipated minors and children living under the care of individuals not legally responsible for that care may be considered one-person families. College students, regardless of their residence, who are supported by their parents or others related by birth, marriage, or adoption are considered to be residing with those who support them.

**INCOME** refers to total cash receipts before taxes from all sources. It includes money, gross wages, gross income from self-employment, rental income, public assistance, social security, unemployment compensation, strike benefits, training stipends, alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the same household; government employee pensions, private pensions, regular insurance or annuity payments; income from dividends, grants, interest, rents, royalties, or income from estates and trusts.

**Please Note:** Doctors fees, radiologist, reference laboratory testing, drugs, ambulance charges, and patient convenience items used during the hospital stay are not covered under this application and will be your responsibility.

We can help you with this form if you have questions. Please call the Financial Counselor at 641.469.4311 or Patient Account Representative at 641.469.4301.

**Please return completed application and required documentation to:**

Jefferson County Health Center
Attn: Financial Counselor
2000 S Main St · Fairfield, IA 52556
Fax: 641.469.4216 · Email: billing@jeffersoncountyhealthcenter.org