

**Section 1: Patient and Guarantor Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Guarantor Name (if patient is a minor) \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip Code: \_\_\_\_\_

Name(s) of <b>Spouse</b> 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)	<b>Please include the most recent copy of the items below</b>
Wages <input type="checkbox"/> Self Employed <input type="checkbox"/>			Current YTD paystubs Recent tax return
Social Security <input type="checkbox"/>			Social Security benefit letter
Pension/Disability <input type="checkbox"/> Rental Income <input type="checkbox"/>			Pension/Disability letter Tax return with schedules
Unemployment <input type="checkbox"/> Workers' Compensation <input type="checkbox"/>			Unemployment letter 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 2023 Charity Care Guidelines

Size of Family Unit	100% CHARITY	90% CHARITY	60% CHARITY	40% CHARITY	20% CHARITY	10% CHARITY	0% CHARITY
1	\$ 14,580	\$ 21,870	\$ 29,160	\$ 36,450	\$ 43,740	\$ 51,030	\$ 58,320
2	\$ 19,720	\$ 29,580	\$ 39,440	\$ 49,300	\$ 59,160	\$ 69,020	\$ 78,880
3	\$ 24,860	\$ 37,290	\$ 49,720	\$ 62,150	\$ 74,580	\$ 87,010	\$ 99,440
4	\$ 30,000	\$ 45,000	\$ 60,000	\$ 75,000	\$ 90,000	\$ 105,000	\$ 120,000
5	\$ 35,140	\$ 52,710	\$ 70,280	\$ 87,850	\$ 105,420	\$ 122,990	\$ 140,560
6	\$ 40,280	\$ 60,420	\$ 80,560	\$ 100,700	\$ 120,840	\$ 140,980	\$ 161,120
7	\$ 45,420	\$ 68,130	\$ 90,840	\$ 113,550	\$ 136,260	\$ 158,970	\$ 181,680
8	\$ 50,560	\$ 75,840	\$ 101,120	\$ 126,400	\$ 151,680	\$ 176,960	\$ 202,240
For each additional Person	\$ 5,140	\$ 7,710	\$ 10,280	\$ 12,850	\$ 15,420	\$ 17,990	\$ 20,560

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 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: 641.472.7803 · Email: [billing@jeffersoncountyhealthcenter.org](mailto:billing@jeffersoncountyhealthcenter.org)