TO APPLY

1. You will need to provide verification of qualification through DHS from your county. Our Cashier or Financial Counselors are on-site to assist with this application process Monday-Friday 8:00 AM - 4:30PM.
2. Attach 3 Forms:
   a. Notice of decision from DHS
   b. A copy of bills with assistance needed
   c. Copy of pay stub with tax return (if not currently employed include verification of other assistance document.
3. Return application and documents to:

   Greater Regional Health
   Business Office
   1700 West Townline Street
   Creston, Iowa 50801

PLEASE CALL WITH ANY QUESTIONS

CASHIER

1700 West Townline Street
Creston, Iowa 50801
Phone: 641-782-3538
Fax: 641-782-3689

BILLING: 1-888-298-9006

E-MAIL:

cashier@greaterregional.org

Greater Regional HEALTH

APPLICATION FOR FINANCIAL ASSISTANCE

GRH

WWW.GREATERREGIONAL.ORG

	Applicant (Guarantor) Information		Spouse or other Adult Household member Information
Name		**Name**	
Address		Address	
City, State, Zip		City, State, Zip	
Date of Birth		Date of Birth	
SSN		SSN	
Contact Phone #		Contact Phone #	
Employer		Employer	
Employer Group Health Offered	Yes_____ or No_____	Employer Group Health Offered	Yes_____ or No_____
If unemployed Last Date Worked:	Last hourly rate:	If unemployed Last Date Worked:	Last hourly rate:

Name and Age of Dependent Children_____

Required documents are a copy of your last income tax return and current paycheck stubs with year to date information.
If you have any of the following other income please provide verifying documentation : Social Security - VA Assistance - Railroad Retirement - Child Support - Disability Pension - Alimony - Unemployment - Workers Comp
Proof of income must accompany your application if you are unwilling to provide this you will not be considered for charity care.

Assets/ Liabilities				Qualified Expenses	
Cash on hand	$	Vehicle – Model/year		Medical Bill at GRMC	
Bank Accounts-Checking	$	Value	$	Medical Insurance	
-Savings	$	Balance Owed	$	Other Medical Bills:	
Investments –Bonds CDs	$	Vehicle – Model/year			
If Owner: Home Value	$	Value	$		
Balance Owed	$	Balance Owed	$		
Other Assets:	$	Other Loans:	$		
	$		$		

Please provide verification of qualification for assistance programs such as FIP, LIHEAP, WIC and SNAP (food assistance). Also provide proof of denial for Medicaid from DHS.

I affirm that the information on this declaration and any related forms are true and correct to the best of my knowledge. I understand that if the information is determined to be false, assistance will be denied or revoked. I authorize Greater Regional Medical Center to verify any or all information given and to obtain a consumer credit report if deemed necessary.

Applicants Signature:_____ Date:_____