EXCLUDED SERVICES:

The following services do NOT qualify for financial assistance.

Sports Physicals
Nursing Student Physicals
DOT Physicals
Dry Needling
Pellet Insertion
CET Injections
Nitrous Oxide
Cateract
(Toric Lens, PanOptix Lens & Vivity Lens)

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

PR 9/24

Greater Regional HEALTH

FINANCIAL ASSISTANCE *Application*

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 income Social Security - VA Assistance - Railroad Retirement - Child Support - Disability

Please provide verifying documentation: 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/Liabitlities				Qualified Expenses		
Cash on Hand	$	Vehicle - Model/year	$	Medical Bill at GRMC		
Banking 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 to obtain a consumer credit report if deemed necessary.

Applicants Signature:_____ Date:_____

Co- applicant Signature:_____ Date:_____