## To Apply

## Follow 3 Short Steps...

1) You will need to provide verification of qualification through DHS from your county. Our Cashier or Patient Advocate is on-site to assist with this application process Monday-Friday

   8:00 AM- 4:30 PM.

2) Attach 3 Forms:

* Notice of decision from DHS

* A copy of bills with assistance needed

* Copy of paystub with tax return (if not currently employed include verification of other assistance document)

3) Return Application and documents to:

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

**Please call with any questions**

Cashier
1700 West Townline Street
Creston, Iowa 50801

CPSI Phone: 1-888-298-9006
Phone: 641-782-3538
Fax: 641-782-3689

E-mail:
cashier@greaterregional.org

GREATER REGIONAL MEDICAL CENTER

# APPLICATION FOR FINANCIAL ASSISTANCE

**Cashier Phone:**
**641-782-3538**
**CPSI Billing Phone:**
**1-888-298-9006**

| | 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:_____

Co-applicant Signature:_____ Date:_____