1801 Hickman Road
Des Moines, Iowa 50314
Financial Counseling Office
Fax: 515-282-2270 Phone: 515-282-2246

broadlawns
MEDICAL CENTER

# Financial Assistance Application

**The following documents are required for processing the Community Care program application:**

**Picture I.D.** MUST BE VALID IOWA STATE I.D. Iowa Driver's License and Iowa I.D.'s can be obtained at the Iowa Dept of Transportation, 6310 SE Convenience Blvd. (just off Corporate Woods Drive) Ankeny, IA 50021. 515-239-1101

**Proof of Social Security number.** This will come from your social security card. If you do not have your social security card available, you may use an income tax return, W2 or any other document that may prove your number.

**Proof of Residency.** We will need proof that you live in Polk County. To do this, we will need documentation. Rent receipts, Utility bills, insurance Statements, or "Official" mail that has been sent to you at your "living address" in the last 30 days. This cannot be a PO Box, a "mailing" address or "junk" mail that is addressed to you or "current resident". We cannot accept mail from Broadlawns Medical Center.

**Proof of Household Income.** We require proof of ALL income received in the last 90 days for all household members. This can be, but not limited to: payroll check stubs, employer letter, award letter from Social Security Administration, disability, child support, foster care, inheritance, and Workers' Compensation documentation. If self-employed, a ledger of expenses and latest federal income tax return. If unemployed a White Sheet from Workforce Development.

**Proof of all Accounts.** To include, but not limited to: Checking, Savings, IRA's, 401K's, CD's, Stocks, Bonds, 403Bs, Trusts, Annuities, IPERS, and any other type of money accounts. Account statements from the past 90 days.

**Medical insurance.** Medicare card, Medicaid card, medical insurance cards, Veterans Administration card, etc. for all household members.

**Other:** Any other information requested by the Financial Counselor to determine your eligibility.

broadlawns MEDICAL CENTER

Date _____
Medical Record Number _____

## APPLICANT INFORMATION

Full Name _____ Date of Birth _____
Social Security Number _____ Primary Language _____
Gender M F U.S. Citizen Y N U.S. Veteran Y N Disabled Y N
Marital Status (choose one) Single (never married) Married Separated
Divorced Widowed Common Law

## SPOUSE INFORMATION

Full Name _____ Date of Birth _____
Social Security Number _____ Primary Language _____
Gender M F U.S. Citizen Y N U.S. Veteran Y N Disabled Y N

## RESIDENCY

Current Living Address _____
City _____ State _____ Zip Code _____
Mailing Address (if different) _____
City _____ State _____ Zip Code _____
Phone Number _____ Second Phone Number _____
Email Address _____

## CHILDREN WHOSE PRIMARY RESIDENCE IS YOUR HOME

| Name and Date of Birth | Social Security Number | U.S. Citizen |
|---|---|---|
| | | Y N |
| | | Y N |
| | | Y N |
| | | Y N |

## ALL OTHER PEOPLE WHOSE PRIMARY RESIDENCE IS YOUR HOME

| Name | Relationship |
|---|---|
| | |
| | |
| | |
| | |

## EMPLOYMENT INFORMATION

Employed Y N **If unemployed a White Sheet from Workforce Development is required.

Applicant Employer's Name _____ Start Date _____
Address _____ City _____
State _____ Zip Code _____ Employer Phone Number _____

Spouse Employer's Name _____ Start Date _____
Address _____ City _____
State _____ Zip Code _____ Employer Phone Number _____

Other Employer's Name _____ Start Date _____
Address _____ City _____
State _____ Zip Code _____ Employer Phone Number _____

## INCOME

Please list ALL sources of income such as employment, social security, child support/alimony, pension/WC/unemployment, interest, etc.

**If self-employed or have rental income the latest tax return and/or ledger is required.

| Recipient Name | Source of Income | Gross Amount | Frequency Received |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## RESOURCES

| | | | |
|---|---|---|---|
| Checking Account | Y | N | Amount _____ |
| Savings Account | Y | N | Amount _____ |
| IRA | Y | N | Amount _____ |
| CD's | Y | N | Amount _____ |
| Trusts | Y | N | Amount _____ |
| Annuities | Y | N | Amount _____ |
| Stocks/Bonds | Y | N | Amount _____ |
| 401K | Y | N | Amount _____ |
| IPERS | Y | N | Amount _____ |
| Real Estate/Property | Y | N | Amount _____ |

Address _____

Health Insurance? Y N

Name of Insurance _____ Monthly Cost _____

Did you apply for Marketplace coverage? Y N

Pay or receive Child Support? Y N

Who pays/receives _____ Amount _____

Have a current Social Security Disability claim? Y N

Is there an attorney helping with the Disability claim? Y N

Is anyone in the household pregnant? Y N

## AUTHORIZATION

**I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this medical bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bill. I certify that the information in this application is true and correct to the best of my knowledge. I understand it is my responsibility to report any and all changes in household income and insurance status within ten business days.**

_____ _____

**Signature of Applicant** **Date**

_____ _____

**Signature of Applicant's Spouse** **Date**