



Financial Assistance Application

Only complete applications are taken into consideration by Mahaska Health Partnership.

Incomplete applications will be returned and not considered until all documentation is submitted.

If application is for a family or minor children, both father/mother, husband/wife must complete the application.

Personal Information

Guarantor's Full Legal Name: _____ Date of Birth: _____

Patient's Full Legal Name: _____ Date of Birth: _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Home Phone: _____ Marital Status: Single/Married/Divorced/Widowed

Employer (Name/Address/Phone): _____

Name/Address/Phone of a Nearest Relative Not Living With You: _____

Financial Disclosure – To Be Completed

Income for all Members in Household

Expenses

Annual Income from Employment \$ _____

Monthly Rent/Mortgage Payment \$ _____

Annual Income from Investments \$ _____

Monthly Food Allowance \$ _____

Annual Income from Public Assistance \$ _____

Monthly Personal Care \$ _____

Annual Income Other (please specify) \$ _____

Monthly Health Care \$ _____

Annual Income from Social Security \$ _____

Monthly Health/Dental Premiums \$ _____

Annual Income from Rental Property \$ _____

Monthly Education Costs \$ _____

Total Annual Income \$ _____

Monthly Childcare Costs \$ _____

Monthly Utility Costs \$ _____

Resources available

Monthly Clothing Costs \$ _____

Balance in Checking Account \$ _____

Monthly Car Loan \$ _____

Balance in Savings Accounts \$ _____

Monthly Car Insurance \$ _____

Other Resources \$ _____

Monthly Credit Card Payment(s) \$ _____

Other _____ \$ _____

Number of Persons in Family _____

Total Monthly Expenses \$ _____

Attached is an approval/denial from the Department of Human Services, 410 South 11th, Oskaloosa, 641-673-3496 _____

Attached is two pay stubs or 1 yrs Income Tax _____ Other Income Verification _____ Most Recent 30 Day Bank Statement _____

I/We am/are herewith applying for assistance (either through Charity Care or non-Interest payment plans) from Mahaska Health Partnership. I/We verify under penalties of law that everything contained within this application is true and correct to the best of my/our knowledge and that nothing contained in this application was falsified in order to receive assistance. I understand that I/we may be approved for partial assistance in which case, I/we must make a good faith effort to promptly pay the remaining balance which may be owed to Mahaska Health Partnership. I/we hereby authorize Mahaska Health Partnership to verify any information contained in this application (either verbally or in writing), with of the references or creditors shown.

Signature of Applicant

Signature of Co-Applicant

Date: _____

3/2012, 09/2012, 02/2021

Please return completed financial applications to: FinancialCounselors@mahaskahealth.org