**

**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.

Pharmacy Card Application

Financial Assistance – Facility 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 are two pay stubs or 1 yr. 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 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, 10/2022

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