mahaskahealth

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