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 _____

Guarantor's Address _____ City _____ State ____ Zip _____

Patient's Full Legal Name _____ Date of Birth_____

Mailing Address _____ City _____ State ____ Zip _____

Social Security Number _____ Home Phone _____

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

Annual Income from Employment $ _____

Annual Income from Investments $ _____

Annual Income from Public Assistance $ _____

Annual Income Other (please specify) $ _____

Annual Income from Social Security $ _____

Annual Income from Rental Property $ _____

Total Annual Income $ _____

Expenses

Monthly Rent/Mortgage Payment $ _____

Monthly Food Allowance $ _____

Monthly Personal Care $ _____

Monthly Health Care $ _____

Monthly Health/Dental Premiums $ _____

Monthly Education Costs $ _____

Monthly Childcare Costs $ _____

Monthly Utility Costs $ _____

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	$ _____
		Total Monthly Expenses	$ _____

Please provide ALL of the following for EVERY adult in the household:

1. **Number of Adults in Household** _____
2. **Number of Children in Household** _____
3. **Two (2) pay stubs or 1 year Income Tax** _____ **Other Income Verification** _____
4. **Most Recent 30-Day Bank Statement for All Open Accounts (Checking, Savings, Brokerage, etc.)** _____
5. **Approval/Denial Letter from DHS for Medicaid** _____

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, 2/2025, 6/2025

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