Winneshiek MEDICAL CENTER | Physician services by MAYO CLINIC HEALTH SYSTEM

PATIENT FINANCIAL ASSISTANCE APPLICATION

The information you supply in this application is necessary to determine if you qualify for the Patient Financial Assistance Program and the amount of assistance that is available. The eligibility is based on your family size, income and the gross value of your assets. Anesthesiology is billed separately through Winneshiek Medical Center Anesthesia. If you are receiving a separate bill for any anesthesiology billing, you may provide a copy of the bill with this application and Winneshiek Medical Center Anesthesia will take into consideration your eligibility. Pathology is billed separately though Upper Iowa Pathology and is not included in the program. Please answer all the questions and indicate N/A when the question does not apply to you.

Name:_____ Phone: _____

Street/PO Box _____ City _____ State ____ Zip Code _____

Date of Birth _____ Social Security #_____ Marital Status _____

Number of family members that live with you _____

Are you employed? _____ Yes _____ No

	Applicant	Spouse
Your employer is:	_____	_____
Length of Employment:	_____	_____
Hourly Wage:	_____	_____
Gross Monthly Income:	_____	_____
Cash on Hand:	$_____	
Checking Account:	$_____	
Savings Account:	$_____	
Time Certificates or Other Investments:	$_____	

Examples of Other Sources of Income:

SOCIAL SECURITY	WELFARE	VA PENSION
WORKERS COMPENSATION	RETIREMENT INCOME	FOOD STAMPS
UNEMPLOYMENT	RENTAL INCOME	INHERITANCE
CHILD SUPPORT	UNION BENEFITS	OTHER

Who receives this income?	Source of Income	Amount Received
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

EXPENSES

	MONTHLY PAYMENT	BALANCE
Mortgage/Rent	$_____	$_____
Second Mortgage	$_____	$_____
Personal/Home Equity Loans	$_____	$_____
Property Insurance	$_____	$_____
Water, Sewer, Garbage	$_____	$_____
Electricity & Fuel	$_____	$_____
Telephone/Cell Phone	$_____	$_____
Cable TV	$_____	$_____
Food	$_____	$_____
Child Care	$_____	$_____
Child Support	$_____	$_____
Education Loan(s)	$_____	$_____
Auto Loan(s)	$_____	$_____
Auto (Gas, Repairs, etc.)	$_____	$_____
Credit Card(s)	$_____	$_____
Life Insurance	$_____	$_____
Health Insurance	$_____	$_____
Medication Bills	$_____	$_____
Doctor's Bills	$_____	$_____
Hospital Bills	$_____	$_____
Other:	$_____	$_____

Have you applied for any financial assistance programs within the last year (Social Security Disability, Medicaid/Title 19, Medically Needy, County Relief, Veterans Affairs), if so, what is the current status (approved, denied, pending) if denied, WHY?

_____

_____

Please use this space to give any information or circumstances you feel would be helpful for us to understand your current financial situation: _____

_____

_____

_____

_____

_____

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_____

_____

_____

YOU WILL NEED TO PROVIDE A COPY OF THE FOLLOWING DOCUMENTS:

_____ **A complete copy of your Federal and State Tax Return**

_____ **Paycheck stub showing year to date income**

_____ **Verification of Social Security, Disability, Alimony or Unemployment Income**

_____ **A copy of last months checking and savings account statements**

_____ **Department of Human Services Medicaid Eligibility Letter**

I understand that the information submitted is subject to verification (as necessary) by Winneshiek Medical Center. I certify that this information is true and correct to the best of my knowledge.

_____ _____

Signature Date

Please sign the statement and return this form along with copies of the required documents to:

Winneshiek Medical Center
Business Office
Attn: Financial Representative
901 Montgomery Street
Decorah, IA 52101
563.382.1966

You may be contacted for a personal interview regarding your request for assistance.
You will be notified by mail of your eligibility.