Montgomery County Memorial
Hospital + Clinics
712.623.7000 2301 Eastern Ave, PO Box 498, Red Oak, IA 51566 www.mcmh.org

Application for Financial Assistance

Attached you will find an application for Financial Assistance. Please complete all blanks. If you need extra space to record your information, please use the back of the page.

Documents Needed

- ☐ Bank Statements (3 months, optional for Emergency and Outpatient)
- ☐ Child support verification
- ☐ Social Security or Disability benefit verification
- ☐ Pay stubs (3-6 months)
- ☐ Previous year income tax return

If all information is received with your completed application, consideration of your request of Financial Assistance will be processed. You should receive a letter in the mail regarding the status of the application.

Any and all members of the household that have income must do income verification. Please make sure that you have included all items needed. This will increase the speed of processing your claim.

If you should have any questions please contact:

Kim Smelser
Resource Counselor (712-623-7274)

Montgomery County Memorial Hospital + Clinics
Financial Assistance Application

In order to offer financial assistance, we must substantiate your financial need. This application must be completed to the best of your knowledge. Additional information may be requested.

Applicant: _____
Address: _____
City,State,Zip: _____
Phone Number: _____
Date of Birth:_____
Marital Status (Optional): _____

Spouse/Other: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Date of Birth: _____
Marital Status (Optional): _____

Household Members:

Name:	**Date of Birth:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Income

	Applicant	**Spouse/Other**
Gross Wages	_____	_____
Farm/Self Employed	_____	_____
Alimony	_____	_____
Unemployment	_____	_____
SSI/SS Benefits	_____	_____
Inheritance	_____	_____
Pension/IRAs	_____	_____
Dividends	_____	_____
Interest	_____	_____
Rental Income	_____	_____
Work Comp	_____	_____
Other	_____	_____

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information given is to be used to ascertain my ability to pay for services provided by Montgomery County Memorial Hospital + Clinics. I hereby grant permission to Montgomery County Memorial Hospital + Clinics to investigate the information contained herein.

_____ _____
Applicant Signature Date

_____ _____
Spouse/Other Signature Date

Lack of information or needed documents could delay the determination of your application.

If an application has been intentionally falsified the application is automatically denied, and applicant will no longer be able to apply for financial assistance in this facility.

REVISED 01/11/2024