Montgomery County Memorial Hospital
2301 Eastern Ave. P.O. Box 498
Red Oak, IA 51566

Financial Assistance

Montgomery County Memorial Hospital offers Financial Assistance to low-income Montgomery County and the surrounding service area residents (which includes Mills, Fremont, Page, Cass and Adams County) who do not have insurance or do not qualify for any government assistance through the County, Title XIX, or wish the remaining balance after insurance has paid to be considered for assistance through the Hospital's program. Because the Hospital does not receive any government assistance for this service and may write off a portion or all of the patient's bills, we first require the patient to apply for Medicaid through the Department of Human Services.

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

____ Public Aid approval or denial letter (If applicable-pregnant, dependent children, medically needy, disabled, blind or over the age of 65)
____ Bank Statements (3 months)
____ Child support verification
____ Social Security or Disability benefit verification
____ Pay stubs (3-6 months)
____ Previous years 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
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.

Name: Applicant:_____ Spouse/Other:_____
Address: _____ _____
City,State,Zip: _____ _____
Phone Number: _____ _____
S.S Number: _____ _____
Marital Status: _____ _____

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

Assets	**Location**	**Amount**
Cash on Hand	_____	$_____
Checking Accounts	_____	$_____
Savings Accounts	_____	$_____
Inheritance	_____	$_____
Pension/IRAs	_____	$_____
Dividends	_____	$_____
Interest	_____	$_____
Total Assets	$_____	$_____

Income	**Applicant**	**Spouse/Other**
Gross Wages	_____	_____
Farm/Self Employed	_____	_____
Alimony	_____	_____
Unemployment	_____	_____
SSI/SS Benefits	_____	_____

Public Assistance

__ Medicaid/Public Aid __Food Stamps __Housing Asst. __ County Relief

Other Sources of Income (please check appropriate boxes)

	Recipient	**Amount Received**
Rental Income	_____	_____
Workers Compensation	_____	_____
Other	_____	_____

Please provide copies of checks for income verification for any items checked above.

If both parties are unemployed please provide information as to how your monthly expenses are paid:

_____

_____

Please use the space below to give any information you feel would be helpful in understanding your current situation.

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. I hereby grant permission to Montgomery County Memorial Hospital to investigate the information contained herein.

_____

Applicant Signature Date

_____

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.