Keokuk County Hospital & Clinics

KCHC Application for Financial Assistance

In recognition of Keokuk County Health Center's policy to provide quality health care to all persons regardless of their financial status, the financial assistance program provides assistance to those in need in a fair non-discriminatory manner.

Bad Debt is defined as payment not received for services rendered for which payment is anticipated and credit is extended. Bad debt patients do not meet the criteria for financial assistance; that is they are considered able to pay, but unwilling to satisfy their outstanding obligations.

Financial Assistance Instructions

1. A completed application must be returned to the hospital for consideration within 30 days of issue.
2. Eligibility discount is based on income and family size and no other factors (e.g., assets, insurance status, participation in the Health Insurance Marketplace, citizenship, population type.
3. Keokuk County Health Center reserves the right to request verification of income, refusal of an applicant to provide any requested information may result in denial of financial assistance.
4. Provide documentation showing denial of assistance through Keokuk County's General Assistance Program, State Medicaid, and Medicare. Optional for emergency room and outpatient clinic visits.
5. Keokuk County Health Center will submit a response to the applicant within 14 working days of the receipt of a completed application and supporting information.
6. Only **ONE** financial assistance determination will be made per episode or series of care.
7. Financial Assistance Applicants will be responsible for paying the balance remaining on an account after any assistance has been granted **WITHIN 60 DAYS (unless prior arrangements have been made)**. Failure to pay the remaining balance may cancel any assistance granted on the account.
8. Complete all the questions on the application for financial assistance.
9. Enter employment information for both husband and wife. If unemployed enter "unemployed" under employer, indicate date of unemployment under employment date and indicate current monthly gross income.
10. Other income sources should include income from self employed business ownership, farm and any other income received.
11. Complete cash assets section for both husband and wife. (Optional)
12. Both husband and wife must sign and date the application.
13. Please submit the Following information along with your application. Financial assistance **will not** be provided without the requested information.
    - ☐ **Copy of your most recent paycheck stub/voucher**
    - ☐ **Verification or monthly income from Social Security if applicable**
    - ☐ **Verification of unemployment income if applicable**
    - ☐ **Copy of your _____ calendar year signed Federal Tax Return**
    - ☐ **Copy of last month's complete bank checking and savings account statement.**

If you have questions call the business office at 641-622-1157.

Keokuk County Hospital & Clinics

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Date Issued _____

Date Received _____

KCHC Application for Financial Assistance

Patient Account Number(s)

_____

Date of Service _____

Name of Patient _____

APPLICANT INFORMATION

Patient First Name _____ Middle _____ Last _____

Date of Birth _____ / _____ / _____ SSN *(Optional)* _____ / _____ / _____

City/State/Zip _____

Telephone Number (_____) _____ Cell Phone Number (_____) _____

Spouse First Name _____ Middle _____ Last _____

Date of Birth _____ / _____ / _____ SSN *(Optional)* _____ / _____ / _____

Residence ☐ Own ☐ Rent _____ Are you a United States Veteran? ☐ Yes ☐ No Is your spouse? ☐ Yes ☐ No

Amount of Rent / Mortgage _____ Are you required to file a tax return? ☐ Yes ☐ No Is your spouse? ☐ Yes ☐ No

DEPENDENT INFORMATION

Number of Adults _____ Number of Children _____

Names and Ages of Children _____

EMPLOYMENT INFORMATION

First Name	Employer	Length of Employment	Full Time	Part Time	Pay Period Weekly Monthly Bi-Monthly, etc.	Hours Worked Per Pay Period	Hourly Pay

OTHER INCOME SOURCES

	Applicant	Spouse	Total Amount Received
Unemployment Benefits	☐	☐	$ _____
Disability Benefits	☐	☐	$ _____
Social Security Benefits	☐	☐	$ _____
Child Support	☐	☐	$ _____
Alimony	☐	☐	$ _____
Interest Income	☐	☐	$ _____
Pension Benefits	☐	☐	$ _____

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ASSETS *(Optional)*

Financial Institution	Names on Account	Checking Account Number	Checking Account Balance	Savings Account Number	Savings Account Balance

OTHER ASSETS *(Optional)*	Applicant	Spouse	Cash Value
Stocks / Bonds / C.D.	☐	☐	$ _____
Life Insurance	☐	☐	$ _____
Land / Buildings / Equip	☐	☐	$ _____
401k / Retirement	☐	☐	$ _____
Savings Plan	☐	☐	$ _____

Comments _____

I certify that all information listed is true and correct to the best of my knowledge. I understand that the information given is to ONLY be used to ascertain my ability to pay for services provided. I hereby grant permission to Keokuk County Health Center to investigate the information contained herein.

Applicant Signature _____ Date _____

Spouse Signature _____ Date _____

Send completed application to: Business Office
Keokuk County Hospital & Clinics
23019 Highway 149
Sigourney, IA 52591

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Approval Percentage _____ %

Approved By _____ Date _____