LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

Financial Assistance Program Application

If you are underinsured and meet specific eligibility criteria, you are not required to complete this application.

- ☐ Homelessness
- ☐ Deceased with no estate
- ☐ Mental incapacitation with no one to act on patient's behalf
- ☐ Medicaid eligibility, but not date of service

Enrollment in low-income assistance programs:

- ☐ Women, Infants and Children Nutrition Program (WIC)
- ☐ Supplemental Nutrition Assistance Program (SNAP)
- ☐ Iowa Free Lunch & Breakfast Program

APPLICANT INFORMATION:

Applicant Name: (First, Middle, Last)	Social Security #:		Date of Birth:
Address:	City:	State:	Zip:
Primary Phone Number:	Additional Phone #:		
Employment Status: ☐ Employed ☐ Self-Employed ☐ Retired ☐ Disabled ☐ Unemployed - last date worked: _____			
Employer Name: (if applicable)			
Employer Address:	City:	State:	Zip:
Name of Health Insurance plan offered by employer (including COBRA): ☐ Health insurance not provided			

HOUSEHOLD INFORMATION:

Beginning with yourself, list all persons living in your home.

Name:	Date of Birth:	Relationship:

REAL ESTATE INFORMATION

What is the status of your primary residence?

☐ Rent Home ☐ Purchasing Home ☐ Own Home ☐ Homeless ☐ Other: _____

Do you own other real estate? ☐ Yes ☐ No

If yes, where? _____ Value: _____

FINANCIAL RESOURCES/INCOME

Bank Name: _____Checking Balance: _____ Savings Balance: _____

Stocks/Bonds/CDs: _____ Life Insurance Value: _____

Income: *List all income received by persons living in your home, including income from work, self-employment, social security, veteran's benefits, unemployment, child support, alimony, workers compensation, retirement, IPERS, pensions, civil service, etc.*

Source:	Amount Received:	How Often Received:	Person Receiving:
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Unemployment			
Other			
Other			

If your financial assistance application shows no income at all, please describe how you provide for your every day living expenses, such as housing, food, clothing, etc.

_____

_____

_____

MEDICAL RESOURCES

Do you have health insurance? ☐ Yes ☐ No
If yes, is insurance obtained through your employer? ☐ Yes ☐ No
If no, does your employer offer health insurance? ☐ Yes ☐ No

Name of Insurance Company: _____
Address: _____
Policy Holder Name: _____ Policy Number: _____

If you do not have insurance, have you applied for Medicaid? *(We may require that you do so.)*

☐ Yes, awaiting approval ☐ Yes, not eligible ☐ No

If you have not applied, check the items below that apply.

☐ You are 19 years or younger
☐ You are 65 years or older
☐ You are blind
☐ You are pregnant
☐ You take medication to control diabetes, high blood pressure, or seizures
☐ You are disabled as determined by the Social Security Administration
☐ You have children under the age of 19 living with you

Please submit most recent filed tax returns and documentation of income received for the past three months. Please do not send original documents as items submitted with your application will not be returned to you.

SIGNATURE

Please read and sign below:

I certify that the information given on this application and any attached supporting document are accurate and complete to the best of my knowledge. I authorize Lucas County Health Center to verify information provided in this application.

Signature of Applicant: _____ Date: _____