HANSEN FAMILY HOSPITAL
641-648-7018

SPIRIT OF SHARING FINANCIAL APPLICATION

PLEASE COMPLETE THIS FORM FULLY AND RETURN IT *WITHIN 10 DAYS*. THIS APPLICATION CANNOT BE PROCESSED OR ASSESSED WITHOUT INCOME VERIFICATION. *IF YOU HAVE NO INCOME, PLEASE PROVIDE EXPLANATION OF HOW YOUR LIVING EXPENSES (HOUSING, FOOD, UTILITIES, ETC.) **ARE** PAID*. THANK YOU.

Account Number_____ Account Balance _____

Patient Name_____ Date of Birth _____

Address _____ Telephone _____

_____ Social Security Number _____

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR THE INDIVIDUAL RESPONSIBLE FOR PAYMENT

Name_____ Date of Birth _____

Address (if different) _____ Telephone _____

_____ Social Security Number _____

PLEASE PROVIDE THE FOLLOWING FOR ALL HOUSEHOLD MEMBERS (Attach additional sheet if necessary)

Name	Date of Birth	Relationship to Patient	Social Security Number

Do you have insurance? ___ No ___Yes Do you have Medicaid? ___No ___ Yes
Do you have Medicare? ___No ___Yes
Are you or someone in your household a veteran? ___No ___Yes If yes, Name_____

HOUSEHOLD INCOME FROM EMPLOYMENT

Person Employed	Employer	Gross Pay	Per
			__ **Wk** __ 2 **Wks** __ **Mo**__
			__ **Wk** __ 2 **Wks** __ **Mo**__
			__ **Wk** __ 2 **Wks** __ **Mo**__

HOUSEHOLD INCOME FROM OTHER SOURCES

Child Support / Alimony Received ..... $ _____
Food Stamps / Foster Care / Township Trustee / Church ..... $ _____
Income/Assistant/Lunch Programs, etc..... $ _____
Pension / Social Security / Social Security Disability..... $ _____
Rental Property..... $ _____
Stocks, Bonds, Annuities, Interest..... $ _____
Unemployment or Worker's Compensation..... $ _____
Other..... $ _____

TOTAL MONTHLY GROSS INCOME: $ _____

OTHER INFORMATION WE SHOULD KNOW TO ASSIST IN OUR UNDERSTANDING OF YOUR FINANCIAL SITUATION: _____

_____

_____

_____

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****Please include verification of income, 3 recent pay stubs, bank statements or tax return with all schedules.****

I certify that all information is true and complete to the best of my knowledge. I understand that the information provided will be verified and treated as personal and confidential. I further authorize Hansen Family Hospital to obtain banking information and employment information. I authorize the release of any and all information from the Iowa Division of Family and Children Services. **I understand that I must provide verification of income.** I also understand that I will be liable for full payment of any services rendered at Hansen Family Hospital if the above information is given under false pretenses.

Signature _____ Date _____

OFFICE USE ONLY
Approved for financial assistance No _____ Yes _____ What % _____
Renewal Date _____
Denial Reason:
_____