Wheaton Franciscan Healthcare

Services Provided By:

❑ Covenant Medical Center
❑ Covenant Clinic
❑ Sartori Memorial Hospital
❑ Covenant Home Medical
❑ Mercy Hospital – Oelwein

COMMUNITY CARE FINANCIAL APPLICATION

In recognition of Wheaton Franciscan Healthcare's policy to provide quality health care to all persons regardless of their financial status, Wheaton Franciscan Healthcare's Community Care program provides financial assistance to those in need in a fair, non-discriminatory manner.

Community Care Financial Application Instructions

Submit the following checked (✓) Items:

(please send copies, originals will not be returned)
All information is needed for both applicant and spouse

- ☑ Copy of your most recent paycheck stub/voucher.
- ☑ Verification of monthly income from Social Security if you are retired or on disability.
  (Example: Bank Statement or Award Letter)
- ☑ Verification of unemployment income.
- ☑ Verification of child support and/or alimony.
- ☑ Verification of pension and/or work comp benefits.
- ☑ Verification of food stamps, FIP Assistance, heating and housing assistance.
- ☑ Applicants that receive financial help from a family member or other person for living expenses must include written statement from this person.
- ☑ Complete copy of your _____ calendar year signed Federal Tax Return including all schedules if you are self employed and/or have farm or rental real estate income.
- ☑ If you do not have health insurance
  1. A letter from your employer and/or your spouse's employer, confirming health insurance coverage is not available.
  2. If you declined health insurance offered through your employer and/or your spouse's employer, submit cost of the premiums.
- ☑ If you do have health insurance:
  1. Proof of premiums you are paying for health insurance coverage.
- ☑ Letter of decision regarding public funded health insurance coverage is required.
  Please call your local Department of Human Services office to apply for Medicaid/Title 19 and/or medically needy spend down program.

Wheaton Franciscan Healthcare will submit a written response to the applicant upon receipt of a completed application and supporting information.

IF YOU HAVE QUESTIONS, PLEASE CALL 1-800-728-0159 OR 319.272.0044.

Please return completed application and documentation to: **Wheaton Franciscan Healthcare**
Attn: Credit Department
3421 West 9th Street
Waterloo, IA 50702-9989

Date: _____ Account Number(s):_____

Applicant's Name: _____ Patient's Name _____
Applicant's Address:_____ City:_____ St:_____ Zip:_____
Applicant's Phone No: _____ SSN_____ Date of Birth _____
Marital Status: ❒ Single ❒ Married ❒ Widowed ❒ Divorced
Spouse's Name:_____ SSN _____ Date of Birth _____

Dependent's Name	Date of Birth	Dependent's Name	Date of Birth
_____	_____/_____/_____	_____	_____/_____/_____
_____	_____/_____/_____	_____	_____/_____/_____
_____	_____/_____/_____	_____	_____/_____/_____

EMPLOYMENT, INCOME AND INSURANCE INFORMATION (ALL BLOCKS MUST BE COMPLETED):
APPLICANT

Are you presently employed?.....❒ Yes ❒ No Do you file federal tax return? ..... ❒ Yes ❒ No
Are you self-employed?.....❒ Yes ❒ No Do you have health insurance?..... ❒ Yes ❒ No
Hire Date: _____ Monthly amount paid for health insurance: $_____
How often are you paid?: ❒ Weekly ❒ Bi-Weekly ❒ Monthly Hourly Wage: $_____
How many hours are you scheduled each pay period? ❒ 20 ❒ 40 ❒ 60 ❒ 80 ❒ 120 ❒ Other_____
Present or Last Employer:_____ City: _____ State: _____
Monthly Gross Income: _____ Telephone Number:_____

SPOUSE OF APPLICANT

Are you presently employed?.....❒ Yes ❒ No Do you file federal tax return? ..... ❒ Yes ❒ No
Are you self-employed?.....❒ Yes ❒ No Do you have health insurance?..... ❒ Yes ❒ No
Hire Date: _____ Monthly amount paid for health insurance: $_____
How often are you paid?: ❒ Weekly ❒ Bi-Weekly ❒ Monthly Hourly Wage: $_____
How many hours are you scheduled each pay period? ❒ 20 ❒ 40 ❒ 60 ❒ 80 ❒ 120 ❒ Other_____
Present or Last Employer:_____ City: _____ State: _____
Monthly Gross Income: _____ Telephone Number:_____

OTHER SOURCES OF INCOME (check type and list amount):

- ❒ Alimony/Child Support _____
- ❒ Social Security _____
- ❒ Veteran's Pension_____
- ❒ Unemployment Compensation _____
- ❒ School Grants_____
- ❒ Pension Annuity_____
- ❒ Workman's Compensation_____
- ❒ Rental Income _____
- ❒ Other (Specify) _____

I CERTIFY THAT THE INFORMATION GIVEN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I authorize the release of information to Wheaton Franciscan Healthcare for verification of this financial statement.

_____ _____
Signature of Patient/Applicant Date

_____ _____
Spouse Date