Financial Assistance Application

Thank you for inquiring about the Financial Assistance Program at Loring Hospital. Please fill out the attached application and return it with the required documentation below within 30 days. If your completed application has not been received within the specified timeline, your account will be subject to our standard billing procedures. When Loring Hospital has received your completed application, it will be reviewed to determine your level of qualification. You will be notified of our determination within 30 days of receipt.

Applicants are required to apply for Medicaid before financial assistance will be considered. If you would like assistance completing your Iowa Medicaid application, or this application, please contact our Financial Counselor at (712)-662-7105 located in the Business Office at Loring Hospital.

Along with the completed application, copies of the following documents are also required. Any application returned without a signature, or the appropriate documentation will not be considered.

Documentation Check List: PLEASE DO NOT SEND ORIGINALS

- Last filed Federal Income Tax Return, if applicable (Must be within two years)
- Most Recent Bank Statement
- Three consecutive months of proof of income (i.e., paycheck stubs); if on Social Security, please have a copy of the Benefit Verification letter.
- Proof of DHS (Medicaid) Application; notice of decision (if applicable)
- Proof of Residency (i.e. utility bill or mail with your physical address)

UNSIGNED OR INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED FOR ASSISTANCE

Return the Financial Assistance Application and required attachments to:

Loring Hospital
Financial Assistance
211 Highland Ave
Sac City, IA 50583

Or via fax at (712) 662-6438

For assistance in completing this form or for any questions, please contact our financial counselor at 712-662-7105

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To assist us in determining eligibility for possible financial assistance, the following application must be completed in full.

Applicant Name _____
Last Name First Name Middle Initial

Date of Birth _____ Social Security Number _____

Phone Number _____
Home Work Mobile

Email Address _____

Preferred Method of Contact _____

Home Address _____
Street City State Zip Code

How long have you lived at your current address _____

Do you ☐ rent ☐ own ☐ live with friends/family ☐ residential treatment center

I have applied for or will apply for federal or state Medicaid assistance or have verified my healthcare exchange plan eligibility

☐ yes ☐ no Reason _____

I have a lawsuit, settlement, personal injury, or liability claim pending

☐ yes ☐ no Reason _____

Applicant Employment Status (check one) ☐ full time ☐ part time ☐ self employed ☐ unemployed ☐ retired ☐ disabled

Employer Name _____

Employment Length _____

Unemployment Date/Length _____

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Spouse Employment Status (check one) ☐ full time ☐ part time ☐ self employed ☐ unemployed ☐ retired ☐ disabled

Employer Name _____

Employment Length _____

Unemployment Date/Length _____

Spouse/Dependents (living in your household) *if more than four dependents, use separate sheet

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Name _____ Age _____ Relationship _____

Bank Accounts	
Account Type	**Current Balance**
Checking	
Savings	
Other Investments/Securities	
Other	

Property	
Type	**Estimated Value**
Secondary Residence/Vacation Home	
Land	
Rental Property	
Other/Recreational Vehicle	

Applicant Income Description	Source	Monthly Income Amount
Primary Job Wages		
Secondary Job Wages		
Interest/Dividends		
Pension/Retirement		
Rental/Property		
Disability/Social Security		
Alimony/Child Support		

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Applicant Income Description	Source	Monthly Income Amount
Workers Compensation		
Other		

Spouse Income Description	Source	Monthly Income Amount
Primary Job Wages		
Secondary Job Wages		
Interest/Dividends		
Pension/Retirement		
Rental/Property		
Disability/Social Security		
Alimony/Child Support		
Workers Compensation		
Other		

Government Assistance	Yes / No	Approved	Denied
Disability / SSI			
Title XIX/Medicaid			
Medically Needy			
General Relief			
Food Stamps			
Utility Assistance			
Housing Assistance			
Other (Specify)			

If there are other extenuating circumstances that would be helpful to us in understanding your need for financial assistance, please use this space to explain:

_____

_____

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I/We hereby certify that I/We are of legal age and that the foregoing statements are true and complete and made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this application shall remain property of Loring Hospital, whether the application is accepted. I/We agree to provide necessary verification of my/our income. I/We authorize the verification of any reported information on this application by Loring Hospital

_____ _____

Applicant Signature Date

_____ _____

Spouse Signature Date

Business Office Use Only:

FPL percentage _____

Approved Financial Assistance percentage amount _____%

Percentage due from the patient _____%

Financial Assistance Active Dates _____

Applicant Notified _____

Notes _____

_____

_____

_____ _____

Financial Counselor Signature Date