GRUNDY COUNTY MEMORIAL HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

Instructions for completing the Financial Assistance Application

1. Reason for Application: Please write a brief explanation of your current situation and why you need assistance with your bill.

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2. Complete all areas of application.

3. Date and sign the application.

4. Please submit the following information with your application. *Failure to provide requested information, or separate explanation as to why the information was not submitted, will result in an incomplete application.* Financial assistance cannot be provided without requested information.

   Submit the following items as applicable (If not applicable, please explain why):

☐ Paycheck/unemployment check stubs (last 3 months).

☐ Most recent Federal and State Tax Returns (including all supporting documents).

☐ Most recent certified financial statement. (Business owners/Self-employed)

☐ Checking and Savings Account Statements (past 3 months).

☐ Statement of monthly benefit from Social Security.

☐ Other:

The application will not be processed unless the application is completely filled out and accompanied by the requested income verification.

Your application and all supporting documents may be submitted via:

Mail:
Grundy County Memorial Hospital
Attn: Patient Accounts Manager
201 East J Avenue
Grundy Center, IA 50638

Fax:
(319) 824-3337
Write "FA Application" on the fax cover sheet.

****If you have any questions, please call (319) 824-5421 for the Patient Accounts Manager.**

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Name of Applicant | Home Phone

Street Address/PO Box | Work Phone

City | State | Zip Code

Name of Co-Applicant | Home Phone

Street Address/PO Box | Work Phone

City | State | Zip Code

_____
Number of Dependents

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Please attach a copy of the following documents:

1. **Last Year's Tax Return**
2. **Last 3 Month's Income**
3. **Checking and Savings Account Balances**
4. **Short and Long Term Investment Account Balances**

I certify that the information provided in the document is true, complete and correct to the best of my knowledge and belief.

Signature of Applicant | Date

Signature of Applicant | Date

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EXPENSES:	**MONTHLY PAYMENT**	**UNPAID BALANCE**
HOUSE HOLD:		
Mortgage/Rent	_____	_____
Utilities	_____	_____
Other (Explain)	_____	_____
EDUCATION RE-PAYMENT LOAN	_____	_____
INSURANCE:		
Auto	_____	
Real Estate	_____	
Health	_____	
Renters	_____	
CHILD CARE	_____	
CHILD SUPPORT/ALIMONY	_____	
CAR/TRUCK PAYMENT	_____	
CREDIT CARDS		
BANK LOANS (personal)	_____	_____
MEDICAL BILLS:		
Physicians	_____	_____
Dentist	_____	_____
Hospital	_____	_____
Home Medical Equipment	_____	_____
Home Health	_____	_____
Pharmacy	_____	_____
TOTAL MONTHLY EXPENSES	**_____**	**_____**

OTHER:

List All Other People Living in the Household

Name	Relationship	Social Security No.	Birthdate

GRUNDY COUTNY MEMORIAL HOSPITAL
FINANCIAL ASSISTANCE APPLICATION

INCOME:

Applicant's Net Income _____
Spouse's Net Income _____
Other Income: _____
(Alimony, Child Support, VA, Welfare, Social Security, Other)

TOTAL MONTHLY INCOME _____

ASSETS:

Checking Account _____
Savings Account _____
Stocks/Bonds/CDs _____

Vehicles: (Cars, Trucks, Motorcycles, Boats and Trailers)

Model_____Year_____Monthly Payment _____
Model_____Year_____Monthly Payment _____
Model_____Year_____Monthly Payment _____
Model_____Year_____Monthly Payment _____

Total Market Value _____
Total Loan Balance _____

Land

Market Value _____
Loan Balance _____

Mortgage

Market Value _____
Loan Balance _____

Other Assets: (Please Attach a List)

Market Value _____
Loan Balance _____

TOTAL ASSETS _____