



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

1. A completed application must be returned to the hospital for consideration within 30 days of the date issued.
2. To be eligible for community care assistance, each applicant must meet minimum gross income requirements set by the Federal Government and cash asset requirements to qualify and receive financial assistance.
3. Wheaton Franciscan Healthcare reserves the right to request verification of income. Refusal of an applicant to provide requested information would result in denial of community care assistance. Please follow the instructions regarding income verification on the reverse side of this page.
4. Wheaton Franciscan Healthcare will submit a response to the applicant within 10 working days of the receipt of a completed application and supporting information.

Community Care Assistance will not be granted in any of the following circumstances:

- A. Fraudulent information at time of registration or on application for financial assistance. (Examples: Name, Address, Employment, Income, Assets).
- B. Any portion of an account balance payable or expected to be payable by any third party.
- C. All accounts currently in collections are not eligible for assistance.

Instructions for Completing Community Care Financial Application

1. Both husband and wife will need to date and sign the application.
2. Please submit the following information with your application. **Failure to provide requested information or a separate explanation as to why the information was not submitted would result in an incomplete application.** Community Care assistance cannot be provided without requested information.
3. Financial information is required from both parents if the patient is a child even if parents are not married.
4. Please note: **Any blank spaces may disqualify or delay processing of your application.** Complete the form in ink.

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.
- Verification of unemployment income.
- Verification of child support and/or alimony.
- Verification of pension and/or work comp benefits.
- 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.
- Copy of last month's complete bank checking/savings account statement showing 30 days of activity.
- Letter from both your employer and your spouse's employer, confirming health insurance coverage is not available through this employer. This must be on company letterhead with contact name and phone number.
- Letter of decision regarding public funded health insurance coverage is required. Please call your local Department of Human Services office to apply for both:
 1. Medicaid/Title 19 (this includes all spend down programs)
 2. Iowa Care
- Copy of your state issued photo id.
- Property tax statement showing assessed value of your property.
- Statement from mortgage lender showing balance due.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 1-800-728-0159 OR 319-272-7190.



Wheaton Franciscan Healthcare

In Partnership with Schoitz Health Resources

3421 West Ninth Street
Waterloo, IA 50702-5401
Tel 319.272.0044

Services Provided By:

- Covenant Medical Center
- Sartori Memorial Hospital
- Mercy Hospital – Oelwein
- Covenant Clinic
- Retail Regional Services

COMMUNITY CARE FINANCIAL ASSISTANCE

Date: _____ Account Number(s): _____

Applicant's Name: _____ Patient's Name _____
 Applicant's Address: _____ own rent reside w/family other
 Applicant's Phone No: _____ SSN _____ Date of Birth _____
 Marital Status: Single Married Widowed Divorced Separated
 Spouse's Name: _____ SSN _____ Date of Birth _____

Number of Dependents: _____
 Dependent's Name: _____ Age: _____ Dependent's Name: _____ Age: _____
 Dependent's Name: _____ Age: _____ Dependent's Name: _____ Age: _____
 Dependent's Name: _____ Age: _____ Dependent's Name: _____ Age: _____

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

Are you presently employed? Yes No Are you self-employed? Yes No
 Are you required to file federal tax return? Yes No

Applicant

Spouse of Applicant

Present or Last Employer	Present or Last Employer
Street Address Telephone Number	Street Address Telephone Number
City State Zip	City State Zip
Supervisor's Name Telephone #	Supervisor's Name Telephone #
Monthly Net Income	Monthly Net Income
Employment Dates From: _____ To: _____ (Require previous employment information if less than 1 year)	Employment Dates From: _____ To: _____ (Require previous employment information if less than 1 year)

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) _____

Homeowner

Other Property

Location:	Location:
Assessed Taxable Value:	Assessed Taxable Value:
Mortgage Balance:	Mortgage Balance:

CAR INFORMATION

Make and Year	Model	Lien Holder (if other than applicant)	Value	Loan Balance	Monthly Payment

APPLICANT ASSET DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Checking				
Savings				
CDs, IRAs, etc.				
Stocks, Bonds, etc.				
Cash-on Hand				
Income Property				
Other Assets (boat, motorcycle, snowmobile, etc.)				

APPLICANT LIABILITIES DETAILS (This information will be verified)

Description	Name on Account	Financial Institution and Address	Account Number	Balance
Mortgage				
Car Loan				
Credit Cards				
Other				

LIFE INSURANCE Policy Type Term Whole Cash Value _____

Are you on active military duty? _____ Branch of Service: _____

Are you a veteran? _____ Dates of Service: From: _____ To: _____

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

***** If you desire financial consideration for payment of your hospital charges, a copy of your current tax return must accompany this form.

OFFICE USE ONLY	
Recommendations: _____	
Monthly Payment: \$ _____	First Payment Due: _____
Approved <input type="checkbox"/> Declined <input type="checkbox"/>	
Comments _____	Date _____