

Lakes Regional Healthcare
Charity Care Application

To assist Lakes Regional Healthcare in the determination of your eligibility, the following information must be completed in full. If something does not pertain to your status, please fill in with N/A. If you would like assistance in completing the application, please contact the Lakes Regional Healthcare Business Office at (712) 336-8700. Return the completed application along with the required documentation to the Business Office.

- Required documents:** Most recent tax return and W-2 forms for all household members
Proof of income for the last three months for all household members
Statement of unemployment compensation benefits for all household members
If applicable, denial or status of application from the Social Security Disability Administration
Current Public Assistance denial for medical assistance from Department of Human Services
Current denial from the Community General Relief Assistance Office

Name: (Last) _____ (First) _____ (MI) _____

Date of Birth: _____ Social Security Number: _____

Home Address: _____

City, State, Zip: _____

Other Name: (Last) _____ (First) _____ (MI) _____
(Other referring to Spouse, significant other, or other adult in household)

Other Date of Birth: _____ Other Social Security Number: _____

Do you (circle one) own your home rent your home live with family/friends

How long at current address: _____ Landlord Name/Phone Number: _____

Home Phone Number: _____ Cellular Phone Number: _____

Relative Name and Phone Number (not living with you): _____

Members of Household: (If additional space is needed, please list on a separate sheet of paper)

Name	Birthdate	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

EMPLOYMENT INFORMATION

Employer's Name: _____ Other's Employer's Name: _____
Occupation: _____ Other's Occupation: _____
Employer's Address: _____ Other's Employer's Address: _____
Employer's Phone Number: _____ Other's Employer Phone Number: _____
How long at current employer? _____ How Long at current employer? _____

If less than 3 months – list previous employer for past three months

Who was employed	Employer Name	Length of time at employment
_____	_____	_____
_____	_____	_____
_____	_____	_____

INCOME

Income from employment for all household members:

Hourly Wage: _____ Hours per week: _____ Other's Hourly Wage: _____ Hours per week: _____
Salary: (Gross) _____ (week/month) Other's Salary: (Gross) _____ (week/month)

If there is another adult (non-spouse) contributing to your household, please list their name and contribution:

Other Sources of income for all household members:

Pensions _____ Alimony/Child Support _____
Unemployment _____ Public Assistance _____
Interest/Dividend Income _____ Insurance Settlements _____
Lawsuits/Structured Settlements _____ Other (please describe) _____

Please list dollar amounts for the following:

Stocks: _____ Bonds: _____ CDs: _____

ASSETS

Real Estate Location: _____ Bank Name (if financed) _____

Market Value: _____ Amount Owed: _____

Rental Property Owned: Yes ___ No ___ Rental Income: _____

(If yes above, please list locations, market value and amount owed on a separate sheet of paper.)

Auto: Make _____ Model _____ Year _____

2nd Auto: Make _____ Model _____ Year _____

Recreation Vehicles (Type and Value): _____

Checking Balance: _____ Account Number: _____ Bank Name: _____

Savings Balance: _____ Account Number: _____ Bank Name: _____

Cash on hand: _____

Monthly Expenses

Rent or House Payment _____ Car Payment _____

Homeowners/Rental Insurance _____ Car Insurance _____

Lights/Heat _____ Medical Insurance _____

Water/Sewer _____ Life Insurance _____

Telephone _____ Cellular Phone _____

Internet Services _____ Cable Television _____

Food/Supplies _____ Entertainment _____

Clothing _____ Child Support _____

Child Care _____ Misc. (please specify) _____

Please list ALL loans (Personal, bank, credit cards, medical expenses, retail, student loans, etc.) that you are paying on monthly. If needed, use an additional sheet of paper.

Name of Creditor	What was Purchased	Amount Financed	Unpaid Balance	Monthly Payment

If there are extenuating circumstances that would help us in determining your need for financial assistance, please explain on a separate sheet of paper.

I/We hereby certify that I/We are of legal age and that the foregoing statements are true and complete and are made for the purpose of determining my/our eligibility for financial assistance. I/We agree that this statement shall remain the property of Lakes Regional Healthcare, whether or not the application is accepted. I/We agree to provide the necessary verification of my/our income and authorize Lakes Regional Healthcare to make all inquiries that you deem necessary to verify the accuracy of the statements made herein, and to determine my/our credit worthiness, including, but not limited to, procuring consumer reports from reporting agencies, and credit information from banks and other financial institutions and extenders of credit, present and former employer's, merchants, landlords and other creditors. If approved for Community General Relief assistance, I/We agree to provide a copy of the approved Community General Relief application to Lakes Regional Healthcare. I/We further agree that Lakes Regional Healthcare will be provided payment from Community General Relief in the pro-rata share of medical expenses approved by Community General Relief.

Signature of Applicant _____ Date _____

Signature of Other Applicant _____ Date _____

Reminder: Please be sure that all required documents are attached

Lakes Regional Healthcare will process all information provided and a notice of decision will be issued