

Adair County Health System Financial Assistance Application

If you have any questions regarding this form, please call *Ashlee* at 641-743-7236.

Basic Information ** All Adults residing in the household must be listed**

Name: _____	Date of Birth: _____	Telephone Numbers
Address: _____		Home _____
City/State/Zip: _____		Work _____
Employed: Y/N Unemployed: Y/N Retired: Y/N		Cell _____

Name: _____	Date of Birth: _____	Telephone Numbers
Address: _____		Home _____
City/State/Zip: _____		Work _____
Employed: Y/N Unemployed: Y/N Retired: Y/N		Cell _____

****If more than two adults reside in the household please list all individuals with basic information on a separate sheet of paper and attach to this application.****

Name & Date of Birth of ALL Dependents of Household (Full time Students under age 25)

Name: _____	DOB: _____	Name: _____	DOB: _____
Name: _____	DOB: _____	Name: _____	DOB: _____
Name: _____	DOB: _____	Name: _____	DOB: _____

PROOF OF INCOME: SUBMIT APPLICABLE PROOF OF INCOME LISTED BELOW FOR ALL ADULTS LISTED ABOVE

- | | |
|--|---|
| <input type="checkbox"/> Federal Tax Return (most recent) REQUIRED | <input type="checkbox"/> Paystub with Year to Date information (most recent) REQUIRED |
| <input type="checkbox"/> Social Security <input type="checkbox"/> VA Assistance <input type="checkbox"/> Pension/ Retirement | <input type="checkbox"/> Alimony <input type="checkbox"/> Disability <input type="checkbox"/> Life Insurance <input type="checkbox"/> Public Assistance |
| <input type="checkbox"/> Unemployment <input type="checkbox"/> Workman's Comp. <input type="checkbox"/> Child Support | <input type="checkbox"/> Other: Please List _____ |

By signing below I understand that I assume full responsibility for the accuracy of the statements on this form. I understand that the Adair County Health System will use these statements to determine my eligibility for the Financial Assistance Program. Any approved financial assistance will only apply to services that are billed by ACHS. Other outside specialty providers who bill for their own services will not be considered under this application. I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF. ****All adults residing in the household listed above must sign and date below****

Signature of Applicant _____ **Date** _____

Signature of Applicant _____ **Date** _____