Adair County Health System Financial Assistance Application

If you have any questions regarding this form, please call *the Financial Counselor* at *641-743-7266.*

***Attention** All Adults residing in the household must be listed. All applicants must apply for Medicaid or provide proof of Medicaid application. Contact our Financial Counselor for assistance if needed.*

Name: _____ Date of Birth: _____ Telephone Numbers

Home _____

Address: _____

Work _____

City/State/Zip: _____

Cell _____

Employed: Y/N Unemployed: Y/N Retired: Y/N

Name: _____ Date of Birth: _____ Telephone Numbers

Home _____

Address: _____

Work _____

City/State/Zip: _____

Cell _____

Employed: Y/N Unemployed: Y/N Retired: Y/N

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

□ **Federal Tax Return (most recent) REQUIRED** □ **Paystub with Year to Date information (most recent) REQUIRED**

□ Social Security □ VA Assistance □ Pension/ Retirement □ Alimony □ Disability □ Life Insurance □ Public Assistance

□ Unemployment □ Workman's Comp. □ Child Support □ 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 servies 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 BELEIF. ***All adults residing in the household listed above must sign and date below****

Signature of Applicant _____ **Date** _____

Signature of Applicant _____ **Date** _____