ATTACHMENT I **CONFIDENTIAL**

Floyd Valley Hospital dba/Floyd Valley Healthcare
Financial Assistance Application &
Patient Financial Information

This form is to provide information to assist you in satisfying your financial obligation to Floyd Valley Healthcare.

Applicant Name _____

Current Address _____

City _____State____Zip_____

Home Telephone _____

Renting _____ Buying _____ Years lived at ___

Applicant Social Security # _____

Applicant Birth Date _____

Marital Status: S M D W Sep Other

Spouse or Significant Other Name _____

Spouse Social Security # _____

Spouse Birth Date _____

Spouse Phone # _____

Please list dependents: (attach separate sheet if necessary)

Name	**Age**	**Relationship**	**Name**	**Age**	**Relationship**
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Applicant Employer _____

Position _____ Years Employed ___

Spouse or Sig. Other Employer _____

Position _____ Years Employed ___

Have you applied for or do you have Medicaid coverage? Yes _____ No _____ If not, why?_____

Are you currently a student? Yes _____ No _____

If you are under the age of 26 does your parent's employer offer healthcare coverage for you?
Yes _____ No _____

Applicants should apply for Medicaid and any other potential financial assistance programs before completing this application for Financial Assistance. **If you have any questions regarding financial assistance or information required on this application, please contact the Business Office at Floyd Valley Healthcare or Floyd Valley Clinics. You may contact the Business Services Manager at 712-546-3343.**

Please return with most recent copies of your W-2, tax return, pay stubs and bank statements.

Floyd Valley Healthcare

Monthly Household Income	Applicant	Spouse/Other Household Members	Monthly Household Expenses	Applicant/Spouse/ Other Household Members
Employment (Gross/Net Pay)	$_____	$_____	Rent/Mortgage	$_____
Social Security/Disability	$_____	$_____	Food	$_____
Retirement/Veteran Pension (all sources)	$_____	$_____	Car Payments	$_____
Unemployment Comp.	$_____	$_____	Child Care	$_____
ADC/WIC/Food Stamps	$_____	$_____	Transportation/car expense	$_____
Alimony/Child Support	$_____	$_____	Medical/Dental*	$_____
Investment/Interest Income	$_____	$_____	Insurance (car, medical, etc..)	$_____
Other (List_____)	$_____	$_____	Credit Card (_____)	$_____
Total Monthly Income	$_____	$_____	Collection Agencies	$_____
Net Monthly Income	$_____	$_____	Clothing	$_____
Total Income last 12 months	$_____	$_____	Other (List_____)	$_____
Copy of Tax Return and last 2 months pay stubs are required.			**Total Monthly Expenses**	$_____

ASSETS (Current market value)			**LIABILITIES**	
Cash on hand/Bank/Savings		$_____	Medical Bill* _____	$_____
Investments/CD's (Market value)		$_____	Medical Bill *_____	$_____
Loan/Cash value of Life Insurance		$_____	Medical Bill *_____	$_____
Residence: sq. ft. total _____			Credit Card(s)	$_____
Purchase Price	$_____		Loan on furniture & Appliances	$_____
Estimated Value Now		$_____	Home Loan (current balance)	$_____
Primary Vehicle: Year/Model _____		$_____	Vehicle Loan (current balance)	$_____
Other Vehicle: Year/Model _____		$_____	Real Estate Loan (current balance)	$_____
Farm Real Estate: # of acres _____		$_____	Amount owed on farm equip.	$_____
Farm Equipment		$_____	Amount owed on livestock	$_____
Livestock		$_____	Loan on Rental Property	$_____
Rental Property		$_____	Loan on Business	$_____
Business		$_____	Amount owed on other	$_____
Other _____		$_____	Amt owed to Collection Agency	$_____
	Total Assets	$_____	**Total Liabilities**	$_____

* Out-of Pocket Expense or Liability only (net of any insurance, discounts, third party liability, or any other potential claim)

Were you offered health insurance from your employer? ____Yes ____No
Were you denied health insurance by your employer? ____Yes ____No

Are you eligible for COBRA benefits? ____Yes ____No

I hereby acknowledge that the information given to Floyd Valley Healthcare is true and correct. I authorize Floyd Valley Healthcare to verify any of the information given by me. I will provide documentation of this information upon request.

Signed _____ Date _____

Signed _____ Date _____

INTERNAL USE ONLY

Approved _____ Date _____ Denied_____ Date _____

Signature: _____

Floyd Valley Healthcare