PEOPLES Community Health Clinic

905 Franklin Street, Waterloo, IA 50703 (319) 874-3000
118 S. Main Street, Clarksville, IA 50619 (319) 278-9020

For Office Use
Account#
Date Received
Number in HH
Total Income
SF Determination
Financial Info Scanned into Centricity
Staff Initial
DHS Eligibility ❑ Eligible ❑ Not Eligible ❑ Enrollment Counselor Contacted Patient

ANNUAL FINANCIAL ASSISTANCE APPLICATION

Date _____

Name _____ **Date of Birth** _____

Address _____

City _____ **State**_____ **Zip**_____ **Phone Number**_____

Tell Us About Your Family

Spouse's Name:	**Date of Birth:**
Dependent's Name:	**Date of Birth:**
Dependent's Name:	**Date of Birth:**
Dependent's Name:	**Date of Birth:**
Dependent's Name:	**Date of Birth:**
Dependent's Name:	**Date of Birth:**

Tell Us About Your Income

☐ **I DO NOT WISH TO DISCLOSE MY INCOME. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ALL CHARGES AND WILL NOT BE ELIGIBLE FOR A PAYMENT PLAN.** ***Please sign on back page and return this form.***

☐ **I PROVIDED MY INCOME INFORMATION BELOW AND WILL PRESENT PROOF OF THIS INCOME AS NOTED.** ***More details about documents you are required to submit are on the back page.***

Proof of Income	Documents Needed	Self	Spouse
Wages	2 most recent paycheck stubs or W-2	Employer:_____ Hourly Rate: $_____ Hours per Week: ____ Pay Frequency: □ Daily □ Weekly □ Bi-Weekly □ Monthly	Employer:_____ Hourly Rate: $_____ Hours per Week: ____ Pay Frequency: □ Daily □ Weekly □ Bi-Weekly □ Monthly
Unemployment	Award letter or 2 most recent bank statements	Monthly Income: $	Monthly Income: $
Workman's Compensation	2 most recent paycheck stubs	Monthly Income: $	Monthly Income: $
Disability	2 most recent bank statements	Monthly Income: $	Monthly Income: $
Pension	2 most recent bank statements	Monthly Income: $	Monthly Income: $
Social Security	Award letter or 2 most recent bank statements	Monthly Income: $	Monthly Income: $
Child Support	Award letter	Monthly Income: $	Monthly Income: $
Alimony	Award letter	Monthly Income: $	Monthly Income: $
Veteran's Benefits	2 most recent bank statements	Monthly Income: $	Monthly Income: $
Educational Stipend	Award letter or 2 most recent bank statements	Monthly Income: $	Monthly Income: $
Rental Income	Most recent federal tax return	Monthly Income: $	Monthly Income: $
Self-Employment	Most recent federal tax return	Monthly Income: $	Monthly Income: $
Other		Monthly Income: $	Monthly Income: $

(over)

Information About Child Support or Alimony

Do you *(or your spouse)* pay child support or alimony? □ Yes □ No

If yes, list the payment you make each month: $_____

Sign to Show You Approve the Information Provided on this Application

I declare that my financial status is as listed above. I realize Peoples Community Health Clinic, Inc. is utilizing federal tax dollars to assist me in receiving care. I understand that any misrepresentation of information regarding my income is considered fraud against the United States Government. I understand that it is my responsibility to inform Peoples Community Health Clinic, Inc. of any changes in my insurance or income status in a timely manner. Peoples Community Health Clinic, Inc. may release my financial records and any relevant records for audit purposes as needed.

Signature of Patient/Applicant **Date**

Proof of Income Documents Needed

Below are more details about the "Documents Needed" to prove your income. You only need to turn in documents listed next to your source(s) of income in the chart on the front page.

Please include <u>COPIES</u> of this information when you turn in this application. Originals will not be returned.

- Paycheck Stubs: Two most recent paycheck stubs dated within the last three months
- W-2: Must be from the most recent calendar year
- Award Letter: Must state reason for, start date, and amount of payment
- Bank Statements: Two most recent bank statements dated within the last three months
- Federal Tax Return: Must be from the most recent calendar year

Patients With No Insurance

Patients with no insurance are encouraged to provide a notice of decision regarding eligibility for insurance through the Marketplace (Affordable Care Act). If you need assistance in processing your application through Healthcare.gov or the Iowa Department of Human Services, please contact our Outreach and Enrollment Coordinator at (319) 874-3350.

IF YOU HAVE ANY QUESTIONS,
PLEASE CALL THE BILLING DEPARTMENT AT (319) 874-3000.
PRESS 7 FOR BILLING, THEN 1 FOR FINANCIAL ASSISTANCE.