WCHC

Request Date _____

Due Date _____

Washington County Hospital and Clinics • PO Box 909 • Washington, IA 52353

Section 1: Patient and Guarantor Information

Patient Name_____ Date of Birth___/___/____ Marital Status _____

Guarantor Name (if patient is a minor)_____ Contact Phone Number _____

Address_____ City _____State _____ Zip Code _____

Employer _____ Occupation _____

Name(s) of Spouse and additional dependents	Date of Birth	Relation to Patient

Section 2: Insurance Information

Name(s) of your insurance company _____

Section 3: Income Information

Income Source	Gross Monthly Income Amount	Gross Monthly Income Amount for Spouse or Second Parent	If your balance is over $2,000: Include the most recent copy of the items below
Wages			Last three pay stubs
Self Employed			Tax Schedule F, C or C EZ
Social Security			Social Security Letter
Pension/Disability			Pension/Disability Letter
Unemployment			Unemployment Letter
Workers' Compensation			Workers' Compensation Letter
Interest Income			
Other (Bank/Investments)			

If you have no income, please provide your last date of employment and explain how you meet basic living needs:

_____

If you did not file income taxes please explain why:

_____

Section 4: Expense Information

Expense Source	Balance Due	Monthly Payment	Description
House Payment/Rent			
Utilities – Lights, Water, Phone, Cable			
Insurance – Vehicle, Home, Life, Health			
Loans – Vehicle, Education			
Credit Card Payments			
Medical Bills – Doctor, Pharmacy, Dentist			
Other			
Total Expenses			

Signature

By signing this form, I agree that:

- The information on this form is correct.
- Washington County Hospital and Clinics may confirm the information on this form, or obtain a credit report.
- I am a current legal resident of the state of Iowa.

Patient/Guarantor _____ Date_____

WCHC

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Thank you for choosing Washington County Hospital and Clinics for your care.
Listed below are the documents you will need to include with your Financial Assistance Application.

Please submit copies of all supporting documents, keep the originals for your records
Missing documents or incomplete information will result in a delay in the processing of your application

Patient Balance $2000 or less

- A completed and signed Patient Financial Assistance Application
- Your Medicaid response letter
- Include a copy of a photo ID or a valid Iowa driver's license

Patient Balance greater than $2000

- Completed and signed Patient Financial Assistance Application
- Your Medicaid response letter
- 3 most recent pay stubs for yourself, spouse if applicable and second parent if patient is a minor
- Include proof of income for all income sources listed on the application
- Include a copy of a photo ID or a valid Iowa driver's license
- Include a complete copy of your last filed tax return
- Other documentation may be deemed necessary

Mail, email or fax the complete form and other documents to:

Washington County Hospital and Clinic
Attn: Financial Assistance
PO Box 909
Washington, IA 52353

Fax: (319) 863-3928
Email: patientbilling@wchc.org Attn: Financial Assistance

If you have any questions, please call **(319) 863-3911**