CASS COUNTY MEMORIAL HOSPITAL
APPLICATION FOR UNCOMPENSATED CARE

You may be eligible for uncompensated care. In order for the hospital to make that determination, complete the following information. The hospital will advise you in writing regarding the decision.

I. Name:____ Age:________________
Address:____
City, State, Zip:____ County:______________
Telephone: (____)________________ Social Security Number:______________________________
Your Employer:____________________________________ How Long?________________
Spouse's Employer:_________________________________ How Long?________________
Family Size - Household (Name and relationship):______________________________________
____
Do you have hospital insurance? ☐ Yes ☐ No
If yes, Company:___________________________________ Policy:_____________________

II. Financial Data for Household (Please provide written evidence of all income and resources. This can take the form of paycheck stubs, tax returns, W-2s, bank statements, etc.)

	Total for Last 3 Months	Total for Last 12 Months
Gross Wages		
Farm or Self-Employment		
Public Assistance		
Social Security		
Unemployment Compensation		
Workmen's Compensation		
Strike Benefits		
Alimony		
Child Support		
Military Family Allotments		
Pensions		
Dividends, Interest, Rents		
Other income		
Total Income		

Resources	Amount	As of Date	Location
Cash on Hand			
Checking Account			
Checking Account			
Savings Account			
Savings Account			
Time Certificates			
Stocks			
Bonds			
Other Resources			
Total Resources			

(over)

III. Other Information:

Have you made application to your county Department of Human Services for assistance in payment of your hospital services? ☐ Yes ☐ No If you have, please state the results:

____

____

If you have not applied, state reason for not applying:____

____

Do you have any insurance policies which have a cash surrender value?_____________________

Explain:____

____

Other information that may be of benefit in making a determination:____________________________

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I affirm that the information reported in this application for uncompensated care is true and correct to the best of my knowledge. I authorize the verification of any reported information on this application by Cass County Memorial Hospital.

______________________________________ ______________________

Signature of Applicant Date

Return to: Cass County Memorial Hospital, Credit & Collections Department, 1501 East 10th Street
Atlantic, IA 50022

CSA Income Poverty Guidelines
Effective Date: July 1, 2009

Size of Family Unit	Income Guideline	175% of Guideline
1	$10,830	$ 18,952
2	14,570	25,497
3	18,310	32,042
4	22,050	38,587
5	25,790	45,132
6	29,530	51,677
7	33,270	58,222
8	37,010	64,767

For family units with more than eight members, add $3,740 for each additional member in a family. For the 175% guidelines, add $6,545 for each additional member in a family.