ST. ANTHONY
Regional Hospital & Nursing Home

Always Look to the Cross . . . Always St. Anthony

ST. ANTHONY REGIONAL HOSPITAL & NURSING HOME

CARES PROGRAM | FINANCIAL APPLICATION

Please complete the application & return it with the required supporting documents to the Patient Finance Department at St. Anthony Regional Hospital at P.O. Box 628, Carroll, IA 51401. Questions can be directed to (712) 794-5233.

First Name: _____ Middle: _____ Last: _____

Spouse Name _____ Middle _____ Last _____

Your Social Security # _____ Spouse's Social Security # _____

Address:_____

City: _____ State: _____ Zip Code_____

Phone Number: _____ Additional Phone Number: _____

List All Persons Living In Your Home: (*start with yourself*) Consider adding all family members accounts.

Name	Relation	Birth Date	Age	Are you applying for this person?	
_____	SELF	_____	_____	☐ YES	☐ NO
_____	_____	_____	_____	☐ YES	☐ NO
_____	_____	_____	_____	☐ YES	☐ NO
_____	_____	_____	_____	☐ YES	☐ NO
_____	_____	_____	_____	☐ YES	☐ NO
_____	_____	_____	_____	☐ YES	☐ NO

Have you applied for Medicaid (Title XIX)? ☐ YES ☐ NO

- **IF NO, PLEASE STOP!!**
  - **YOU MUST HAVE APPLIED FOR MEDICAID ONLINE AT www.dhs.iowa.gov AND RECEIVED A NOTICE OF ACTION.**

- **IF YES, YOU MUST PROVIDE A COPY OF YOUR DHS NOTICE OF ACTION LETTER**

HEALTH INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☐ NO

If YES, is your health insurance obtained through your employer? _____.

Policy Holder Name _____ Policy Number _____

If NO, does your employer offer health insurance?_____ Name of Insurance Co. _____

INCOME *(List all income the people living in your home receive. Include income from work, self-employment, social security, veteran's benefits, unemployment insurance, child support, worker's compensation, retirement, IPERS, pensions, civil service, cash from friends or relatives etc.)*

Person who receives money	Employer or Income Source	Gross Pay	How often Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ASSETS

Bank Name _____ Checking Balance $_____ Savings Balance $_____

Health Savings Account $_____ Flexible Spending Account $_____

☐ Renting ☐ Buying Home
Monthly Payment $ _____ Value $_____ Amount Owed $_____

Do you own other Real Estate? _____ If yes, where _____ Value $_____

Make/Year of Vehicles _____ _____ Lienholder on Vehicles _____

List any Recreation vehicles owned by you _____

MONTHLY HOUSEHOLD EXPENSES:

Food $_____ Electric $_____ Gas $_____ Water $_____ Cable $_____

Phone $_____ Prescription Medicines $_____ Alimony/Child Support $_____

Insurance Premiums: Health $_____ Auto $_____ Home $_____

Credit Card $_____ _____ _____ _____ Other _____

You must provide along with your completed application, a copy of last year's Federal Taxes. If you are unable to provide your taxes, a copy of the last three (3) months' worth of paystubs, social security income, disability income or any other income your household receives will be sufficient along with the Iowa DHS Notice of Action letter.

PLEASE READ AND SIGN BELOW

I understand that I assume full responsibility of the accuracy of the statements on this form, and I understand that St. Anthony Regional Hospital will use these statements to determine my eligibility for the CARES Program. If any information changes, it is my responsibility to report such changes. I further understand that any false representations or false claims, statements, or documents or concealments of any material fact may result in the immediate termination of any financial assistance granted to me or my family and that I will be liable to repay all amounts of financial assistance previously provided to me.

I certify that the information given on this application and any attached supporting document is accurate and complete to the best of my ability. I authorize St. Anthony Regional Hospital/Clinic to investigate in reviewing my application for financial assistance.

By signing this form I also acknowledge that I have read and agree to the St. Anthony Regional Hospital Financial Assistance Policy and all of the requirements and guidelines.

Signature of Applicant _____ Date _____

Signature of Co-Applicant _____ Date _____

FOR OFFICE USE ONLY	Deadline for Completion: _____
Received on: _____	Approved on: _____