LINN COMMUNITY Care

Patient Assistance Application

Please mail application and required documentation to:

Linn Community Care Women's Services
Attn: Patient Advocate
P.O. Box 2205
Cedar Rapids, IA 52406
319-730-7300

Date___________________________

If you would like to be evaluated for Linn Community Care's financial assistance program, **you will need to complete this application and provide documentation regarding your family's gross annual income (total family income before taxes) within 60 days of your visit.**

Patient Information

Last Name____________________________ First Name __________________________ MI ______ Date of Birth _______________

Members of Household

Please include all persons living in your home for whom you are financially responsible. Please attach an additional sheet of paper if there are additional household members.

Name____**DOB**_____________ **Relationship:**______________ **Employed:** ❑Yes ❑No

Name____**DOB**_____________ **Relationship:**______________ **Employed:** ❑Yes ❑No

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Name____**DOB**_____________ **Relationship:**______________ **Employed:** ❑Yes ❑No

Name____**DOB**_____________ **Relationship:**______________ **Employed:** ❑Yes ❑No

Name____**DOB**_____________ **Relationship:**______________ **Employed:** ❑Yes ❑No

Gross Income for Members of Household

DOES ANY HOUSEHOLD MEMBER LISTED ABOVE RECEIVE

Employment Wages? ❑ Yes ❑ No
Social Security (SSI)? ❑ Yes ❑ No
Social Security Disability (SSDI)? ❑ Yes ❑ No
Retirement Benefits? ❑ Yes ❑ No
Unemployment Wages? ❑ Yes ❑ No
Self Employment Wages? ❑ Yes ❑ No
Workers Compensation? ❑ Yes ❑ No
Other income/support? ❑ Yes ❑ No
Please specify________________________________

YOU WILL NEED TO PROVIDE ONE OF THE FOLLOWING FORMS OF DOCUMENTATION:

- Paycheck stubs (4 consecutive weeks of pay)
- Tax return (most recent tax year)
- W-2's (most recent tax year)

If you do not have the documentation listed above, you will need to include documentation for all that apply below:

- Disability statement
- Social Security Statement
- Form SSA-1099; Social Security Stmt
- Pension statement
- Veteran's Benefit Statement
- Worker's Compensation

I hereby certify that the above information is true. I understand that I will be responsible for 100% of the charges until Linn Community Care receives this application and proof of income. I understand that I have 60 days from the date of service to provide this information.

____ ___________________________ ________________

Patient or Responsible Party Signature Relationship to Patient Date

Row	Column 1	Column 2	Column 3	Column 3	*Column 4*	*Column 5*
1	**Date:**		**Staff Person:**		**Acct #:**	
2	**Annual Benefits:**	**Self**	**Spouse**	**Other**	**Other**	**Total Household Income**
3	Wages:					
4	Social Security Benefits:					
5	Social Security Disability:					
6	Retirement Benefits:					
7	Unemployment Benefits:					
8	Self Employment Wages:					
9	Worker's Compensation:					
10	Other Support: (List) ____________________ ____________________					
11	**TOTAL ANNUAL INCOME:**					

Row				
12	**# of Household Members:**	**200% of FPL Limit:**	**Gross Annual Income:**	**Meets Financial Assistance Guidelines:** **Yes** **No**

Row			A	B	C	D	Self Pay
13	**Eligible for Slide Through** _________ / _________ / _________	**Patient Eligible for Slide Code:**	**A**	**B**	**C**	**D**	**Self Pay**
		Medical - Patient Responsibility	**$10**	**$20**	**$30**	**$40**	**100%**
		Dental - % Patient Responsibility	**0%**	**25%**	**50%**	**75%**	**100%**