Adair County Health System Financial Assistance Application

If you have any questions regarding this form, please call Erika at 641-743-7222.

Basic Information ** All Adults residing in the household must be listed*

Name: _____ Date of Birth: _____ Telephone Numbers

Home _____

Address: _____

Work _____

City/State/Zip: _____

Cell _____

Employed: Y/N Unemployed: Y/N Retired: Y/N

Name: _____ Date of Birth: _____ Telephone Numbers

Home _____

Address: _____

Work _____

City/State/Zip: _____

Cell _____

Employed: Y/N Unemployed: Y/N Retired: Y/N

****If more than two adults reside in the household please list all individuals with basic information on a separate sheet of paper and attach to this application.****

Name & Date of Birth of <u>ALL</u> Dependents of Household (Full time Students under age 25)

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

<u>PROOF OF INCOME: SUMBIT APPLICABLE PROOF OF INCOME LISTED BELOW FOR ALL ADULTS LISTED ABOVE</u>

□ Federal Tax Return (most recent) REQUIRED □ Paystub with Year to Date information (most recent) REQUIRED

□ Social Security □ VA Assistance □ Pension/ Retirement □ Alimony □ Disability □ Life Insurance □ Public Assistance

□ Unemployment □ Workman's Comp. □ Child Support □ Other: Please List _____

By signing below I understand that I assume full responsibility for the accuracy of the statements on this form. I understand that the Adair County Health System will use these statements to determine my eligibility for the Financial Assistance Program. I HEREBY CERTIFY THAT THE STATEMENTS MADE HEREIN ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELEIF. *****All adults residing in the household listed above must sign and date below*****

Signature of Applicant _____ **Date** _____

Signature of Applicant _____ **Date** _____