

Osceola Regional Health Center  
600 9<sup>th</sup> Avenue North, PO Box 258  
Sibley, IA 51249  
Phone: 712---754---2574

### Charity Care Application

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number \_\_\_\_\_  
(Patient)

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
(Guarantor/Responsible Party)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
(Guarantor/Responsible Party)

Telephone: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of Dependent Children: \_\_\_\_\_

#### MONTHLY INCOME

Patients Employer: \_\_\_\_\_  
Self-employed \_\_\_\_\_  
1040 + net income from Schedule C - Depreciation \_\_\_\_\_  
Farmers: 1040 + net Schedule F - Depreciation \_\_\_\_\_

Spouse/Parent Employer: \_\_\_\_\_  
Self-employed \_\_\_\_\_  
1040 + net income from Schedule C - Depreciation \_\_\_\_\_  
Farmers: 1040 + net Schedule F - Depreciation \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
How long \_\_\_\_\_ to \_\_\_\_\_ Gross Wages \$ \_\_\_\_\_  
Unemployed \_\_\_\_\_ How long? \_\_\_\_\_  
Social Security \_\_\_\_\_ \$ \_\_\_\_\_  
Unemployment Comp. \_\_\_\_\_ \$ \_\_\_\_\_  
Worker's Comp. \_\_\_\_\_ \$ \_\_\_\_\_  
Child Support/Alimony \_\_\_\_\_ \$ \_\_\_\_\_  
Public Assistance/Housing/Food Stamps \_\_\_\_\_ \$ \_\_\_\_\_  
Grants \_\_\_\_\_ \$ \_\_\_\_\_  
Pension \_\_\_\_\_ \$ \_\_\_\_\_  
Rental Income \_\_\_\_\_ \$ \_\_\_\_\_  
Investment Interest \_\_\_\_\_ \$ \_\_\_\_\_  
Source: \_\_\_\_\_  
Other Income \_\_\_\_\_ \$ \_\_\_\_\_  
Source: \_\_\_\_\_

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_  
How long \_\_\_\_\_ to \_\_\_\_\_ Gross Wages \$ \_\_\_\_\_  
Unemployed \_\_\_\_\_ How long? \_\_\_\_\_  
Social Security \_\_\_\_\_ \$ \_\_\_\_\_  
Unemployment Comp. \_\_\_\_\_ \$ \_\_\_\_\_  
Worker's Comp. \_\_\_\_\_ \$ \_\_\_\_\_  
Child Support/Alimony \_\_\_\_\_ \$ \_\_\_\_\_  
Public Assistance/Housing/Food Stamps \_\_\_\_\_ \$ \_\_\_\_\_  
Grants \_\_\_\_\_ \$ \_\_\_\_\_  
Pension \_\_\_\_\_ \$ \_\_\_\_\_  
Rental Income \_\_\_\_\_ \$ \_\_\_\_\_  
Investment/Income \_\_\_\_\_ \$ \_\_\_\_\_  
Source: \_\_\_\_\_  
Other Income \_\_\_\_\_ \$ \_\_\_\_\_  
Source: \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

TOTAL \$ \_\_\_\_\_

#### ASSETS

Savings \$ \_\_\_\_\_  
Institution: \_\_\_\_\_  
Checking \$ \_\_\_\_\_  
Institution: \_\_\_\_\_  
Other Assets: \_\_\_\_\_  
\_\_\_\_\_

Cash on Hand \$ \_\_\_\_\_  
Stocks or Bonds \$ \_\_\_\_\_  
Money Market or CD \$ \_\_\_\_\_  
IRA or 401K \$ \_\_\_\_\_  
Primary Residence \$ \_\_\_\_\_  
Property (Land, Secondary Residence) \$ \_\_\_\_\_

**DEBTS / EXPENSES**

**OTHER EXPENSES (including Medical):**

Liabilities		Monthly	
Owing	To Whom	Payment	Balance
Mortgage/Rent	_____		
Real Estate			
Properties	_____		
Bank Loan	_____		
Auto Loan	_____		
Credit Cards:	_____		

	Monthly	
To Whom	Payment	Balance
_____		
_____		
_____		
_____		

The following documents must be provided for patient and guarantor.

The above information will be kept confidential and will only be used in the determination of discount eligibility. The undersigned certifies that the information has been carefully read and is true and correct to the best knowledge of the undersigned.

Signature \_\_\_\_\_ Date \_\_\_\_\_

For Office Use Only

Approved

Denied

Patient Account#: \_\_\_\_\_ Account Balance: \$ \_\_\_\_\_ Amount of Discount: % \_\_\_\_\_