LUCAS COUNTY HEALTH CENTER

An Affiliate of UnityPoint Health

FINANCIAL ASSISTANCE PROGRAM APPLICATION

Date:_____

Name: First_____Middle_____Last_____

Address:_____

City_____State_____Zip Code_____

Phone Number:_____Additional Phone Number:_____

List All Persons Living In Your Home: (Begin with yourself)

Name	Relationship	Age	Social Security Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FINANCIAL RESOURCES

Bank Name_____Checking Balance_____Savings Balance_____

Stocks/Bonds/CD's_____Life Insurance CashValue_____

Rent Home □ Y □ N Purchasing Home □ Y □ N Own Home □ Y □ N

Do you own other Real Estate?_____If yes, where_____Value_____

MEDICAL RESOURCES

Do you have health insurance? □ YES □ NO
If YES, is insurance obtained through your employer? □ YES □ NO
If NO, does your employer offer health insurance? □ YES □ NO

Name of Ins Co_____

Address_____

Policy Holder Name_____Policy Number_____

Along with your application, please submit your Title 19 acceptance/denial letter.

INCOME *(List all income received by persons living in your home. Include income from work, self-employment, social security, veteran's benefits, unemployment insurance, child support,alimony, workers compensation, retirement, IPERS, pensions, civil service, etc)*

Name of Person Receiving Income	**Source of Income or Employer Name**	**Gross Amount**	**How often paid**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please submit most recent filed tax returns and documentation of income received for the past three months. Please do not send original documents as items submitted with your application will not be returned to you.

PLEASE READ AND SIGN BELOW

I certify that the information given on this application and any attached supporting document are accurate and complete to the best of my knowledge. I authorize Lucas County Health Center to verify information provided in this application.

Signature of Applicant _____Date_____