Osceola Community Hospital
600 9th 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_____

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:_____

TOTAL $_____

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/Income _____ $_____
Source:_____
Other Income_____ $_____
Source:_____

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

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

OTHER EXPENSES (including Medical):

To Whom	Monthly 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: %_____