broadlawns
MEDICAL CENTER

1801 Hickman Road
Des Moines, Iowa 50314
Financial Counseling Office
Fax: 515-282-2270 Phone:(515) 282-2246

DOCUMENTATION REQUIRED FOR THE COMMUNITY CARE PROGRAM

1. **Picture I.D.** MUST BE VALID IOWA STATE I.D**.** Iowa Drivers License and Iowa I.D's can be obtained at the Iowa Dept of Transportation, 6310 SE Convenience Blvd. (just off Corporate Woods Drive) Ankeny, IA 50021. 515-239-1101

2. **Proof of Social Security number.** This will come from your Social Security card. If you do not have your Social Security card available, please inform the financial counselor. Replacement Social Security cards can be ordered at the Riverpoint Office Complex, 455 SW 5th Street Suite "F" Des Moines, Iowa. 1-800-772-1213. Office Hours are Monday – Friday: 9am to 3:30pm.

3. **Proof of Residency.** We will need to prove that you live in the Iowa Cares Medical Home Region 5. To do this, we will need documentation. Rent receipts, Utility bills, insurance Statements, or "Official" mail that has been sent to you at your "living address" in the last 30 days. This cannot be a PO Box, a "mailing" address or "junk" mail that is addressed to you or "current resident". We cannot accept mail from sent by Broadlawns Medical Center.

4. **Proof of income.** We require proof of ALL income, received in the last 30 days. This can be, but not limited to: all paycheck remittances for the last 30 days, or employer verification, Social Security statements, workers compensations disbursements, disability income. Child support, Foster Care income, Self Employment. Inheritance

5. **Income Tax Return**. We require a copy of the most recently filed Federal Income Tax return.

   IF Not income/Unemployed. We require a **Shelter – In – Kind letter** (Notice of Support)

6. **Proof of application for Social Security Disability**. This is proven with paperwork from Social Security Administration (515-283-0212) showing the date that the claim was filed or a written statement from any chosen legal representative/Attorney

7. **If you are eligible for Medicaid / Iowa Cares Programs** You are required to apply for The Medicaid / Iowa Cares Programs. Financial assistance may OR may not be available. Your Financial Counselor will assist you in making this determination. Proof of coverage with these programs is required. Your copy of the Iowa Department of Human Service's Notice of Decision will have this information, (Iowa Medicaid, 1900 Carpenter Des Moines 515-286-3635 Office hours are 8:00 am to 4:30 pm Monday-Friday)

8. **You must provide your notice of Food Stamp benefits.** Your copy of the Iowa Department of Human Service's Notice of Decision will have this information, (Iowa Medicaid, 1900 Carpenter Des Moines 515-286-3635 Office hours are 8:00 am to 4:30 pm Monday-Friday)

9. **Birth Certificate**. You will need to provide a Birth Certificate for all eligible persons. Must be a State issued document with the state seal. (Iowa Birth Certificate requests: 515-281-4944. Lucas State Office Building 321 East 12th, Des Moines Iowa.)

10. **Proof of all Accounts** to include, but not limited to: Checking, Savings, IRA's, 401K's, CD's, Stocks, Bonds, 403B's, Trust's, Annuities, IPERS, and any other type of money accounts. We need a copy of a Bank statement showing the amount of funds present in these accounts.

11. **Proof of Child Support Payments.** If you pay child support, you will need to bring in proof of your payments during the last 90 days. Iowa's child support program 1-888-229-9223, weekdays 8:00 a.m. to 5:00 p.m. CST

12. **Other:** Any other information that the Financial Counselor may need to determine your eligibility.

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Vet:_____
Children:_____
Disability:_____
Comm Ins._____
T19 App: _____
PHC:_____
**For Staff Use **

FINANCIAL COUNSELING SCREENING

Date: Thursday, June 20, 2019 **MR#**_____

Applicant	Spouse

FullName:_____ Full Name:_____
Date of Birth:_____age:_____ Date of Birth:_____age:_____
Social Security number_____Social Security number_____
Gender: m / f primary language:_____Gender: m /f primary language:_____
US Citizen: y / n US Citizen: y / n
Marital status (choose one): single (never married) / married / separated / divorced / widowed / common law
Have you ever served in the United States Armed Service? **Yes** / **No** Discharge status? _____

Residency

Current Living address:_____
Mailing address (if different) _____
City:_____ State:_____Zip:_____
Phone:_____2nd phone_____

Children whose primary residence is your home

Name:_____Birthdate:_____ss#_____US citizen y / n
Name:_____Birthdate:_____ss#_____US citizen y / n
Name:_____Birthdate:_____ss#_____US citizen y / n
Name:_____Birthdate:_____ss#_____US citizen y / n
Name:_____Birthdate:_____ss#_____US citizen y / n

Please list all other people living in your home

Name:_____relationship:_____
Name:_____relationship:_____
Name:_____relationship:_____
Name:_____relationship:_____

Employment information

Employer's Name:_____Start date:_____
Address:_____City:_____State:_____zip:_____
Employer phone#_____

Spouse Employer:_____Start date:_____
Address:_____City:_____State:_____zip:_____
Spouse Employer phone#_____

Income

Please list **ALL** sources of income, benefits, support, entitlements, and assistance.

Who Receives	Source of Income	Gross Amount	Frequency Received

Resources

Checking acct: y / n amt$_____ Savings: y / n amt$_____ IRA: y / n amt$_____
CD's: y / n amt$_____ Trusts: y / n amt$_____ Annuities: y / n amt$_____
Stocks/Bonds: y / n amt$_____ 401K: y / n amt$_____ IPERS: y / n amt$_____
Real estate/property y / n amt$_____address:_____

Car: year_____ make_____model_____ owe/own value_____
Car: year_____ make_____model_____ owe/own value_____
Car: year_____ make_____model_____owe/own value_____

Have health insurance? Yes / no Cost per month: $_____
Have other insurance: Yes / no
Pay or receive Child support: Yes / no Amount: $_____who pays / receives: _____
Have a current Social Security Disability claim: Yes / no
What is the original Social Security Application date: _____
Is there an Attorney helping with the Disability claim? Yes / no
Name of your Disability attorney: _____
Received mental health services at Broadlawns in past 13 months: Yes / no
Do you plan to receive mental health services: Yes / no
Is anyone in the household Pregnant: Yes / no

Authorization

I / we authorize Broadlawns Medical Center (BMC) and to any potential investor or insurer of this credit transaction, state records of employment, including information reported by individual employers to the state, and income history, including State Employment Security Agency records. This authorization for this credit transaction only and continues in effect for 365 days from the date of the applicant's execution of this consent unless limited by state law, in which case the authorization continues in effect for the maximum period not to exceed 365 days, allowed by law. Additionally, I / we authorize BMC, its agents or assigns, to verify my past and present employment earnings records, past and present employment status, bank accounts, stock holdings and any other asset balances that are needed. Furthermore, I / we authorize BMC, its agents or assigns, to order a consumer credit report and verify other credit information as needed. A photographic or carbon copy of this authorization (of the signature(s) of the undersigned) may be accepted as the original.
It is the responsibility of the application to report any and all changes in house hold income and insurance status with in ten business days.

_____ _____
Signature of Applicant *date:*

_____ _____
Signature of Spouse of Applicant *date:*