ATTACHMENT II

Sioux Center Health
Financial Assistance Application
Presumptive Eligibility

Patient Name: _____ Patient SSN: _____

Patient Date of Birth: _____ Patient Account Number: _____

Eligibility Criteria that may be considered:

Initial if Yes	Reason for Eligibility
	Homeless or received care from a homeless clinic
	No income
	Participation in Women's, Infant's and Children's programs (WIC)
	Food stamp eligibility
	Subsidized school lunch program eligibility
	Eligibility for other state or local assistance programs that are un-funded (e.g Medicaid spend-down)
	Family or friends of the patient have provided information establishing the household's inability to pay
	Low income/subsidized housing is provided as a valid address
	Patient is deceased with no known estate
	Patient/Grantor is incarcerated, has no assets and is not eligible for parole within the next 18 months.
	Other (Describe):

Verification

Attach documentation or written attestations demonstrating eligibility

Patient Signature: _____ Date: _____

Office Use Only

Approval

Name: _____ Title: _____

Signature: _____ Date: _____