CEDAR COUNTY PUBLIC HEALTH
400 Cedar Street
Tipton, Iowa 52772
563-886-2226
www.cedarcounty.org

Financial Form

Consumer Name _____

Your personal information will be kept confidential.

In order to determine a sliding scale fee in a fair and non-discriminatory manner, the following financial records are required.

- Copy of most recent bank statement (from all accounts)
- Last year's tax return or (check if applicable) _____ I did not file a tax return last year
- Last end of year certificate of deposit record

You may choose not to furnish this information and pay the full fee charges. Please mark below, sign and return this form.

_____ I choose to not furnish my financial information and pay full fee for services rendered.

Consumer/Representative Signature _____ Date _____

Please fill out the following information for MONTHLY recurring expenses. If you have extenuating financial circumstances, please explain on a separate piece of paper. You may also choose to discuss this with us. Please call us if you have any questions.

Household Monthly Income

Wages	$_____
Interest	$_____
Social Security (SS)	$_____
SSI/ADC	$_____
Pensions	$_____
Farm/Business Income	$_____
Dividends	$_____
Rent or Contract Income	$_____

Resources

Checking Account(s)	$_____
Savings Account(s)	$_____
Certificate of Deposit (CDs)	$_____
Stocks/Bonds	$_____
Other	$_____

PLEASE SEE OTHER SIDE →

Monthly Expenses Considered for Fee Adjustments

Medications $_____

Medical Insurances $_____

Medicare Part B $_____ Is this already taken out of your SS check? Yes _____ No _____

Medicare Part D $_____ Is this already taken out of you SS check? Yes _____ No _____

Lifeline $_____

Other Medical $_____ (do not include bills from Cedar County Public Health)

Number of Persons in Household _____

The above information is correct to the best of my knowledge. I understand it is Cedar County Public Health's policy that individuals must first apply for Medicaid before being able to qualify for a reduced fee. The fee will be set in accordance with the current sliding fee scales for each service rendered.

Consumer/Representative Signature _____ Date _____

Relationship to Consumer _____

This must be received in the Nursing office by _____

A self-addressed, stamped envelope is enclosed for your convenience in returning this form to our office. Thank you.

FOR OFFICE USE ONLY

Date: _____

Current Services: PHN_____ HCA _____ HMK _____

Number of Persons in Household _____

Total Monthly Income _____

Total Monthly Expenses _____

Net Monthly Income _____

Total Resources_____

Fee Set: PHN _____ HCA _____ HMK _____