Return Information to:
MAIL: Iowa C.O.P.S.
Attn: Healthcare Committee
PO Box 52
Granger, IA 50109
EMAIL: healthcare@iowacops.org

Healthcare Financial Assistance Application

This application is for survivors of Law Enforcement Officers killed in the line of duty who are not Medicare/Medicade eligible AND were covered under your spouses/parents policy at the time of their death. If you need help to complete this form please email us at healthcare@iowacops.org.

Instructions for completing this form:

Please fill this form out completely and return all required documentation to the Iowa Concerns of Police Survivors Healthcare Committee via email or to our PO Box with Attn: Healthcare Committee in order to be processed. Financial assistance will not be considered to those who do not complete the application process in full; including the requirement for the patient to apply for programs for which they may qualify (i.e. Medicaid). Applying does not imply reimbursement.

Please submit the following documentation:

1. **Household income, proof of insurance cost, and any health care bills you are looking to be reimbursed for in verification noted below**
2. **Letter from the Department your officer was employed by stating coverage benefits at time of death, and current benefits offered to you and your dependents.**
3. **If filing for an adult dependent of the officer (between age 18-26), proof of payment and statement from them as to who should be reimbursed, is required**

Quarterly Due Dates: February 1st, April 1st, July 1st, October 1st.

Primary Survivor Name _____ Birth Date_____

Relationship to Officer _____ Home Phone _____ Cell Phone _____

Address_____ City_____ State_____ Zip_____

Employer Name_____ Work Phone _____

Please list addresses for the last 12 months:

Address	City	State	Zip	From (Month/Year)	To (Month/Year)

Officer's Name _____ Spouse Birth Date_____

Department Officer was employed by _____ Officer's End Of Watch _____

PSOB (Public Safety Officer Benefit) Application Status: ☐ Approved - Date _____ ☐ Denied ☐ In progress ☐ Not Yet Submitted

Additional Dependents that Officer carried insurance for:

Name	Birth Date	Relationship	Name	Birth Date	Relationship

Household Monthly Income

If you are unable to provide copies of the verified information; please provide 3 months bank statements with an explanation on the back of this form.

Type	Survivor Income	Spouse Income (if applicable)	Type of Income Verification Required
Employment Income (Gross)	$	$	❑ Provide paycheck stubs for the last two pay periods
Self-Employment Income (Gross)	$	$	❑ Provide 3 months bank statements
Pension, Retirement, Social Security Income	$	$	❑ Provide your Pension/Retirement statement, and/or Social Security award letter
Unemployment, Disability Income, etc. Check if Disabled/unemployed longer than 6 months	$ ❑	$ ❑	❑ Provide unemployment, disability award letter, or 3 months bank statements
Child Support, Alimony	$	$	❑ Provide a copy of your divorce decree, legal separation notice, or custody agreement
Other Financial Assistance *(Please list source)*:	$	$	❑ Provide an explanation of your income source(s)

Please turn to the back of this form to complete the application.

We ask applicants who apply for financial assistance to look for other funding also. Please check "Yes" or "No".

Does your employer or spouse's employer offer group health insurance? Do ❑ Yes ❑ No If yes, list insurance company: _____
you have other types of insurance such as Allstate, AFLAC, etc.? ❑ Yes ❑ No If yes, list insurance company: _____
Do you have private insurance? ❑ Yes ❑ No If yes, list balance amount: $ _____
Does your employer reimburse you for any deductible or healthcare costs? ❑ Yes ❑ No
Were you denied for healthcare by your previous provider? Please attach a copy of the denial. ❑ Yes ❑ No
Have you applied for state assistance programs (Crime Victims, etc.)? ❑ Yes ❑ No
Are you eligible for COBRA? ❑ Yes ❑ No

Applications will be reviewed quarterly. We will consider claims for dates of service prior to the 1st day of February, May, August and November that have not yet been submitted. Please itemize your outstanding medical expenses (IE Deductible, co-insurance, etc). Please add an additional sheet if you feel there is additional information we should be informed of in order to understand your inability to pay for medical care or premiums. Proof of payment is required and additional verification may be required.

Applying does not imply reimbursement. Please specifically list what you are requesting below:

Month	Premium Cost	Out of Pocket Expense	Notes or explanation
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			
Total Reimbursement Requested			

Additional Information:

I hereby state that the information given herein is true and correct. I authorize any required verification or medical releases. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered.

Responsible Party Signature _____ **Date** _____

Checklist of all required information to complete application process:

- ❑ Front and back of form filled out completely with signature and date
- ❑ Letter from Department stating current coverage/non-covereage
- ❑ Proof of insurance premiums paid AND proof of insurance expenses you are requesting reimbursement for