Financial Assistance Policy Summary and Application

Great River Health System understands there are situations when patients cannot pay for the services provided. If you need help paying for medical services, you may qualify for financial assistance from the health system.

Where to apply and how to request a free copy:

- Online at greatriverhealth.org or fmchosp.com
- In person. Please return completed applications to one of these locations:

Great River Health System	Fort Madison Community Hospital
Patient Billing Department	Business Office
1221 S. Gear Ave.	5445 Avenue O
West Burlington, IA 52655	Fort Madison, IA 52627

- Request a mailed copy by calling 877-404-4763, option 2 or 319-376-1716

Who is eligible?

- Insured and uninsured patients receiving medically necessary or emergency care
- Patients whose household income is between 200% and 300% of the Federal Poverty Guidelines that are updated each year

Note

Patients with no insurance who qualify for financial assistance cannot be charged more than the amount generally billed to patients who have insurance

How to apply

- Complete and sign all sections of the Financial Assistance Application on the back of this summary.
- Provide this information:
  - ☐ Paycheck stubs from the last two months for everyone living in your household above age 18 (excluding high school students)
  - ☐ Social Security income. You can use a copy of your most-recent check, bank statement or benefits letter.
  - ☐ Most-recent state and federal income tax forms
  - ☐ If you are unemployed: state unemployment claims AND final paycheck stub from your last job
  - ☐ Denial letter from the Department of Human Services

Services covered

All inpatient services
Annex
Cancer Treatment
Cardiac Rehabilitation
Cardiology
Day Hospital
Dermatology
Diagnostic Imaging
Digestive Health
Emergency Care
Family Medicine
Gynecology
Heart & Vascular Center
Home Health
Hospice
Internal Medicine
Laboratory
Medicine Specialists
Mental Health
Nephrology
Neurology
Nursery
Obstetrics
Occupational Health
Ophthalmology
Orthopedics
Otolaryngology
Palliative Care
Pediatrics
Physical Therapy
Podiatry
Psychiatry
Pulmonary Rehabilitation
Pulmonology
QuickCare
Radiology
Respiratory Care
Sleep Disorders
Speech Therapy
Surgical Services
Urology
Walk-In Clinic
Women's Health
Wound

Financial Assistance Application

Patient Information

Name _____ Telephone _____
Address _____ Date of Birth _____ Marital Status _____
City _____ State_____ Zip_____ Social Security Number _____

Responsible Party Information (if different from patient)	**Spouse of Responsible Party Information**
Name	Name
Address	Address
City State Zip	City State Zip
Telephone	Telephone
Date of Birth Marital Status	Date of Birth Marital Status
Social Security Number	Social Security Number

Family Members in Household

Name	Date of Birth	Relationship

Income

Source	Amount Received	How Often Received	Person Receiving
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Unemployment			
Other (Explain)			

Please describe your personal situation and your reasons for requesting assistance. This may include but not be limited to your monthly expenses such as mortgage, child support, alimony and loans.

If your financial assistance application is showing no income at all, please describe how you provide for your everyday living expenses such as housing, food and clothing.

I hereby acknowledge that the information given to Great River Health System is true and correct to the best of my knowledge. I hereby authorize Great River Health System to verify this information.

Responsible party signature_____ Date_____

Spouse signature_____ Date_____