Van Diest Medical Center
Standardized Financial Assistance Application (Page 1 of 2)

Patient Information
Account #_____
Name _____
Social Security #_____Date of Birth_____
Did you file taxes last year? ☐ **Yes** ☐ **No**

Patient/Guarantor (Person responsible for bill) Information
Name_____
Social Security #_____Date of Birth_____
Martial Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Street Address_____
City_____
State_____ Zip Code_____
County of Residence_____ Length of Residence _____

Home Phone #_____ Cell Phone#_____

Employer_____
Business Phone #_____
Job Title_____ Length of Employment_____
Wage_____ Hours/Wk_____ Are you paid: ☐ Hourly
☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other
Monthly Income (Gross-Before Taxes)_____
Other Income: (Indicate Source, monthly amount and attach supporting documentation)
☐ **Food Stamps** $_____
☐ **Social Security** $_____ ☐ **Pension** $_____
☐ **Unemployment** $_____ ☐ **Child Support** $_____
☐ **Alimony** $_____ ☐ **Other** $_____

Spouse's Information (Spouse MUST sign application)
Name_____
Social Security #_____Date of Birth_____
Employer_____
Business Phone #_____
Job Title_____ Length of Employment_____
Wage_____ Hours/Wk_____ Are you paid: ☐ Hourly
☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Other
Monthly Income (Gross-Before Taxes)_____
Other Income: (Indicate Source, monthly amount and attach supporting documentation)
☐ **Food Stamps** $_____
☐ **Social Security** $_____ ☐ **Pension** $_____
☐ **Unemployment** $_____ ☐ **Child Support** $_____
☐ **Alimony** $_____ ☐ **Other** $_____
Total Monthly Gross Income for Household $_____
Total Annual Gross Income for Household $_____

CERTIFICATION:
1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand that the information submitted is subject to verification. I authorize Van Diest Medical Center to verify the above information for both guarantor/patient and spouse.

Signature_____ _____
(Patient/Guarantor) Date
Signature_____ _____
(Spouse) Date

Household Members: (if additional space needed attach info to app)
Name_____ Date of Birth_____
Name_____ Date of Birth_____
Name_____ Date of Birth_____

Assistance
Have you applied for Medicaid/Title XIX or any other State or County assistance? ☐ Yes ☐ No
Date of Application_____
Case Worker Name & Phone #_____
Have you filed for bankruptcy? ☐ Yes ☐ No
If yes, date filed_____
☐ Chapter 7 ☐ Chapter 13 Date of Discharge_____

Assets/Resources (only applies to inpatient accounts)
Are you a homeowner? ☐ Yes ☐ No
Estimated Market Value of home_____
Approximate balance due on loan_____
Years left on loan_____
Do you have a checking account? ☐ Yes ☐ No
Bank Name_____ Average balance_____
Do you have a savings account? ☐ Yes ☐ No
Bank Name_____ Average balance_____
Automobiles:
Make Model Year Payment Amount Balance Due
_____
_____
Other Assets/Resources (stocks, bonds, property, business, boat, motorcycle etc._____
_____

Monthly Expenses (only applies to inpatient accounts)
Rent/Mortgage Amount $_____
Utility Costs (heat, air, water etc) $_____
Groceries $_____ Gas for Auto $_____
Auto Insurance $_____ Life Insurance $_____
Medication $_____ Other $_____

	Monthly Payment:	**Payment To:**	**Balance Due:**
Bank Loans:	$_____	_____	$_____
Credit Cards:	$_____	_____	$_____
School Loans:	$_____	_____	$_____
Other Expenses:	$_____	_____	$_____

Total Monthly Expenses $_____

Proof of Income: a copy of the following documentation **must** accompany your application in order to be processed:

- Most recent year Federal and State Tax Returns with **all** required schedules and **W-2s**.
- Two Current Pay Stubs (Guarantor and Spouse)
- Other income documentation such as but not limited to:

☐ **Social Security** ☐ **Food Stamps** ☐ **Pension** ☐ **Alimony**
☐ **Child Support** ☐ **Unemployment** ☐ **Other**

*****Your application will not be considered without the above documentation and may be returned to you along with a letter detailing the documentation missing*****

Important: Guarantor and Spouse (if applicable) **must** sign the back of the application in order to be processed.

OVER

Van Diest Medical Center's Standardized Financial Assistance Application (Page 2 of 2)
Additional Descriptions of Medical Bills (other than those owed to Van Diest Medical Center):

Payment To	Date of Service	Monthly Payment	Balance Due
_____		$_____	$_____
_____		$_____	$_____
_____		$_____	$_____
_____		$_____	$_____
_____		$_____	$_____

TOTAL MEDICAL BILLS OWED TO OTHERS THAN VAN DIEST MEDICAL CENTER: $_____

CERTIFICATION:
1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand that the information submitted is subject to verification. I authorize Van Diest Medical Center to verify the above information for both guarantor/patient and spouse.

Signature (Guarantor/Patient) _____ Date_____

Signature (Spouse) _____ Date_____

ADDITIONAL DOCUMENTATION:
Please note that by signing the application, you have agreed to attach forms of income verification (pay stubs and income tax returns, etc.). In addition, you may attach bank statements, copies of Social Security checks/letters or other documentation. If there is no income, please verify how expenses are being met. It is important to fully explain a lack of income so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach bank statements from the past 2-3 months. All required documentation must be attached for your application to be considered. If the application is incomplete, it will be returned. Van Diest Medical Center will not be responsible for follow-up on incomplete applications.

TO SUBMIT THIS APPLICATION, PLEASE INCLUDE THE FOLLOWING:

- **Completed, signed and dated application by Guarantor and Spouse**
- **Proof of Income**: a copy of the following documentation **must** accompany your application in order to be processed:
  - Most recent year Federal and State Tax Returns with **all** required schedules and **W-2s**.
  - Two Current Pay Stubs (Guarantor and Spouse)
  - Other income documentation such as but not limited to:
    ☐**Social Security** ☐**Food Stamps** ☐**Pension** ☐**Alimony**
    ☐**Child Support** ☐**Unemployment** ☐**Other**

Your application can not be considered without the above documentation and may be returned to you along with a letter detailing the documentation needed

PLEASE MAIL OR HAND DELIVER YOUR APPLICATION PACKAGE TO:

Van Diest Medical Center
Financial Counselor
2350 Hospital Drive, PO Box 0430
Webster City, IA 50595-0430

Phone 515-832-7715

Van Diest Medical Center
Financial Assistance
Information Sheet

Van Diest Medical Center is a nonprofit county entity and exists to serve the public. We are committed to improving the health of uninsured, underinsured, and medically needy patients by offering Financial Assistance for health care services.

Financial Assistance will be offered to all uninsured and insured patients without regard to residency for medically necessary visits. Financial Assistance is available only after all other payment sources are reviewed and determined to have been exhausted.

If the Hospital receives information within 90 days from the Financial Assistance determination decision that indicates that the information relied on in making the charity determination was in error or false, the Financial Counselor, Business Office Manager, and Chief Financial Officer will consider the impact of the subsequent information and may, in their sole discretion, provide additional Financial Assistance and/or revoke previously granted Financial Assistance and require payment of the services that had been considered for Financial Assistance.

All patients without regard to race, color, sex, age, disability, creed, religion, national origin, political belief or residency are eligible for Financial Assistance.

Patients that receive benefits from the programs below can be eligible for 100% Financial Assistance without filling out a financial application by bringing in proof of being in one of these programs:

- Family investment program (Iowa Code chapter 239B)
- Mothers & children program (Medicaid availability to pregnant women & to children who have not reached age 19)
- Iowa family planning network
- County & State relief programs
- Housing assistance
- Barnabas uplift, mission health programs
- Other programs may be added at discretion of the facility
- Limited eligibility (illegal alien 3 day emergency windows Medicaid benefits)

Financial Assistance may be applied for at the time of admission, before discharge or after discharge. Services eligible to be forgiven are those services provided within the current fiscal year (July 1st through June 30th) prior to and following the day a completed application is submitted and eligibility determination is made. A new application is required each new fiscal year for visits within that fiscal year. Financial Assistance will apply to those accounts in bad debt where the visit date was within the current fiscal year. Financial Assistance is not available on accounts that have already been paid in full.

If you think that you may meet the eligibility criteria, please complete the Financial Assistance application and bring with you to the Business Office the last three months' pay stubs, bank statements (checking, savings, business and personal), your most recent income tax return and a current financial statement showing assets and liabilities. The Financial Counselor or Patient Account Representative will obtain copies of pay stubs and tax returns and will determine if request meets eligibility criteria and a written notice will be sent to the applicant within fifteen working days (Monday through Friday), when possible. Written requests and

Wage_____ Hours/Wk_____

information must be returned to Van Diest Medical Center within one month. All information will be held in the strictest confidence.

Failure to complete the forms and provide adequate supporting documentation of the information provided could disqualify the applicant from receiving Financial Assistance.

Each patient denied Financial Assistance may petition the hospital within thirty (30) days for reconsideration based on extenuating circumstances. The patient will be notified of the appeal process in the correspondence informing the patient of the Financial Assistance denial.

Eligibility Criteria

Covered Services:
Services covered include Inpatient and Outpatient based Hospital Services, Clinic services and Professional services that include ER Physician, Van Diest Medical Center Surgeon Services and Anesthesia. Services must be medically necessary services and provided at the Hospital. **Financial Assistance does not cover elective surgical procedures or services that are not billed by Van Diest Medical Center (i.e. Specialty Clinic charges, Radiologist).**

Income:
Income is based on family income. Eligibility for and the amount of benefit, if any, are determined based on a sliding income scale. This scale is a function of the Federal Poverty Guidelines and, as such, will change as those guidelines are adjusted. An applicant may be eligible if his/her income for the 12 months preceding the eligibility determination or the previous three months income annualized meets the following scale:

Table 1 - Poverty Guidelines and Discount Amounts

Poverty Level	125% or Below	126-150%	151-175%	176-200%	201-225%	Above 225%
Minimum Fee	0% Pay	20% Pay	40% Pay	60% Pay	80% Pay	100% Pay
Financial Assistance Write Off	100%	80%	60%	40%	20%	0%
Family Size						
1	$ 12,140	$ 18,210	$ 21,245	$ 24,280	$ 27,315	Above $27,315
2	$ 16,460	$ 24,690	$ 28,805	$ 32,920	$ 37,035	Above $37,035
3	$ 20,780	$ 31,170	$ 36,365	$ 41,560	$ 46,755	Above $46,755
4	$ 25,100	$ 37,650	$ 43,925	$ 50,200	$ 56,475	Above $56,475
5	$ 29,420	$ 44,130	$ 51,485	$ 58,840	$ 66,195	Above $66,195
6	$ 33,740	$ 50,610	$ 59,045	$ 67,480	$ 75,915	Above $75,915
7	$ 38,060	$ 57,090	$ 66,605	$ 76,120	$ 85,635	Above $85,635
8	$ 42,380	$ 63,570	$ 74,165	$ 84,760	$ 95,355	Above $95,355

For family units with more than eight members, add $4,320 for each additional family member
***Highlighted column refers to DHS Income Poverty Guidelines - Effective Date January 13, 2018**

This policy is intended to provide guidelines for Financial Assistance. Van Diest Medical Center reserves the right to make adjustments in unique situations based on facts and extenuating circumstances.

Subsequent DHS poverty guideline updates will be used as they become effective. A schedule is included as part of this policy reflecting the current guidelines and will be replaced as the guidelines are updated.

Income, for purposes of this policy, refers to all cash receipts before taxes from all sources. It includes wages and salaries before any deductions. It includes receipts from self-employment or business or farm after business expenses excluding depreciation. It includes payments from public assistance, social security, unemployment and workers compensation, veteran's benefits, alimony, child support, military family allotments, government and private pensions, insurance and annuity payment, income from dividend, interest, rents, royalties, estates and trusts, college and university scholarships, grants, fellowships and assistantships, gambling and lottery winnings. In addition, income includes resources drawn down from bank accounts, the sale of property, tax refunds, gifts, loans, inheritance, insurance payments, and compensation for injury. The above identified sources of income are not an exhaustive list and are only provided as examples of income.

If an adult member of a household is unemployed, a copy of the person's filing with the Iowa Workforce Development Unemployment Office is required.

Calculate Poverty Level Percentage:

(Annual Income ÷ Income Poverty Level) x 100

Example 1:
The patient has an annual income of $15,000 and is unmarried and has no dependents. According to the poverty guidelines on Table 1, the income threshold for a household size of 1 is $11,880. The patient's income is determined to be at 126% of the poverty guidelines. Referring to Table 1, the patient qualifies for a Financial Assistance write off of 80%.

Annual Income = $15,000
Household size = 1
Income threshold according to Poverty Guidelines (Table 1) = $11,880

($15,000 ÷ $11,880) x 100 = 126%
Discount amount = 80%

Example 2:
The patient is married and has a combined annual income of $50,000 with a household size of 3. According to the poverty guidelines on Table 1, the income threshold for a household size of 3 is $20,160. The patient's income is determined to be at 248% of the poverty guidelines. Referring to Table 1, the patient does not qualify for a Financial Assistance write off.

Annual Income = $50,000
Household size = 3
Income threshold according to Poverty Guidelines (Table 1) = $20,160

($50,000 ÷ $20,160) x 100 = 248%
Discount amount = 0%

Assets:
Assets also affect the amount of benefit that may be awarded. It is not the desire or intent of this policy to force people to sell assets or incur additional debt. However as a county facility, the hospital and its Board of Trustees have certain fiduciary duties to the residents of Hamilton County that requires the Financial Assistance only be granted to those residents truly in need. Therefore, the following asset limits apply:

Individual: Liquid asset threshold equals $1,500.00
Family: Liquid asset threshold equals $3,000.00

Non-liquid assets: (real estate, long term investments, recreational vehicles, boats, etc.) will also be considered and a statement of the fair market value for such assets must be provided.

Liquid assets are those assets that are easily converted into cash. Money market accounts, certificates of deposit (CDs), cash, checking and savings accounts, stocks, bonds, mutual funds, life insurance cash value, 401ks and Individual Retirement accounts (IRAs) are examples of liquid assets. The liquid asset threshold is calculated using these types of accounts.

Liquid asset test for Financial Assistance

If the liquid assets total amount is $1,500 (Individual) or $3,000 (Family) or less, accounts qualify for Financial Assistance.

If the liquid assets total exceeds $1,500 (Individual) or $3,000 (Family) and the excess over $1,500 (Individual) or $3,000 (Family) is more than the outstanding balance, the patient does not qualify for Financial Assistance.

If the patient qualifies under the sliding fee scale for 100% discount and liquid asset total exceeds $1,500 (Individual) or $3,000 (Family) and the excess over $1,500 (Individual) or $3,000 (Family) is less than the outstanding balance, the patient will owe the excess amount and the balance will qualify for Financial Assistance.

If the patient qualifies for a discount between 101% - 225% of the federal poverty level under the sliding fee scale and liquid asset total exceeds $1,500.00 (Individual) or $3,000.00 (Family) and the excess over $1,500.00 (Individual) or $3,000.00 (Family) is less than the outstanding balance, the patient will owe the excess amount plus a percentage of the eligible Financial Assistance amount. The amount owed by patients will be collected from them based on our collection policies.

Example 2: Family of three with $35,000 annual income. Discount rate equals 60% based on sliding fee scale.

Example 1:	**Example 2:**
$4,000.00 Investments/Assets	$4,000.00 Investments/Assets
Less $3000.00 (Family)	Less $3000.00 (Family)
= $1,000.00 Excess	**= $1,000.00 Excess**
Outstanding Balance $3500.00	Outstanding Balance $3700.00
Less excess $1000.00	**Less excess $1,000.00**
Financial Assistance = $2,5000.00	Financial Assistance $2700.00 x 60% = $1620
Patient owes $1,000.00	Patient owes $1000.00 + $1620 = $2620

The total amount of Financial Assistance provided by the hospital during the first year will be determined on a first-come first-serve basis, until the amount budgeted has been exhausted. The hospital will make a determination whether to continue making applications for Financial Assistance at the time the budgeted amount of Financial Assistance has been exhausted.