

Van Diest Medical Center Financial Assistance Information Sheet

Van Diest Medical Center (VDMC) provides, without discrimination, care for emergency conditions and other medically necessary care regardless of financial assistance eligibility or ability to pay. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services, and to advocate for those who are poor and disenfranchised, VDMC will provide Financial Assistance to individuals who meet the criteria established in the financial assistance policy.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with VDMC's procedures for obtaining financial assistance and other forms of payment, and to contribute to the cost of their care based on their individual ability to pay. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to healthcare services, for their overall personal health, and for the protection of their individual assets.

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, residency, or health insurance provider are eligible for Financial Assistance.

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.

Please complete the Financial Assistance application and provide the information requested as outlined on the Financial Assistance application. 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.

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.

If an applicant is determined to be over income guidelines but has medical bills equaling, or exceeding, 20% of the household's annual income, the applicant will receive a discount of 20%. Balances that are in bad debt are not applicable unless the visit occurred within that fiscal year.

Eligibility Criteria

Covered Services:

The Financial Assistance Program (Sliding Fee Schedule Program) is based on Family Size and Income. Services eligible for Financial Assistance may include but are not limited to: Outpatient based Hospital Services, Emergency Room, Outpatient Clinic, Rural Health Clinic services, Ketamine Infusion (for the initial infusion only), Professional services that include ER Physician, Van Diest Medical Center Surgeon Services, and Anesthesia.

Family Size:

Family is defined as: a group of two people or more (one of whom is the householder) related by birth, marriage, or adoption and residing together; all such people (including related subfamily members) are considered as members of one family. Van Diest Medical Center will also accept non-related household members when calculating family size.

Income:

Income is based on household 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 income for the 12 months preceding the eligibility determination, or the previous three months income annualized meets the following scale:

The table below is used as a example guide – if it is not the most current year – visit <https://www.healthcare.gov/glossary/federal-poverty-level-fpl/> for the most current information.

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%
Household Size						
1	\$ 19,563	\$ 23,475	\$ 27,388	\$ 31,300	\$ 35,213	\$ 35,214
2	\$ 26,438	\$ 31,725	\$ 37,013	\$ 42,300	\$ 47,588	\$ 47,589
3	\$ 33,313	\$ 39,975	\$ 46,638	\$ 53,300	\$ 59,963	\$ 59,964
4	\$ 40,188	\$ 48,225	\$ 56,263	\$ 64,300	\$ 72,338	\$ 72,339
5	\$ 47,063	\$ 56,475	\$ 65,888	\$ 75,300	\$ 84,713	\$ 84,714
6	\$ 53,938	\$ 64,725	\$ 75,513	\$ 86,300	\$ 97,088	\$ 97,089
7	\$ 60,813	\$ 72,975	\$ 85,138	\$ 97,300	\$ 109,463	\$ 109,464
8	\$ 67,688	\$ 81,225	\$ 94,763	\$ 108,300	\$ 121,838	\$ 121,839

For household units with more than eight members, add \$6,875 for each extra person.

Above table contains Guidelines Effective for Calendar Year 2025

Calculate Poverty Level Percentage:

(Annual Income ÷ Income Poverty Level) x 100

Example 1:

The patient has an annual income of \$18,225 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 \$19,563. The patient's income is determined to less than 125% of the poverty guidelines. Referring to Table 1, the patient qualifies for a Financial Assistance write off 100%.

Example 2:

The patient has a combined annual income of \$60,000 with a household size of 3. According to the poverty guidelines on Table 1, the income threshold for a household size of 3 is \$33,313 to 59,964. The patient's income is determined to above 225% of the poverty guidelines. Referring to Table 1, the patient does not qualify for a Financial Assistance write off.

FINANCIAL ASSISTANCE APPLICATION

As provided for in Federal law, I hereby request that Van Diest Medical Center (VDMC) make a written determination of my eligibility for uncompensated services at VDMC. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by VDMC, and I authorize release of information upon their request. I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services, and that I will be liable for charges for services rendered.

Complete this application and send to VDMC with the following

- Copy of page from last year's income tax return showing the "adjusted gross income"
- Copy of last three months of paycheck stubs
- Copies of any unpaid or recently paid medical bills from other facilities if above 225% poverty

Please Return To:
Van Diest Medical Center
Financial Counselor
PO Box 430
Webster City, IA 50595-0430

Date of Application	/	/	
Applicant (Guarantor if Patient is a dependent)			
Name			
Date of Birth			
Present Address			
City, State, Zip			
Home Phone			
Cell Phone			
Employer			

Patient Name	
Spouse or Significant Other (living in same household)	
Name	
Date of Birth	
Present Address	
City, State, Zip	
Home Phone	
Cell Phone	
Employer	

Number of Dependents		
List dependents under the age of 18		
Name	Date of Birth	Relationship

Is financial assistance being requested for dependents listed below?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Name	Date of Birth	Relationship

Income Verification: If employed outside of home, provide proof of income for the last three months

Other source of income	Yes or No	Amount	How often is income received?	Name or name(s) of person(s) receiving
Employment Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Social Security (SS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Veteran's Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Child Support/Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Disability Insurance Payments	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Money from Interest, Dividends	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Retirement Plan Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Rental Income	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Other (explain)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

Income tax return was filed last year	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Have you applied for VDMC's Financial Assistance in the last 12 months?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, approximate date of application	/ /
<i>Balances from prior applications will not be adjusted.</i>		

Questions
Contact our Financial Counselor
515-832-7716

I hereby acknowledge that the above information, given to VDMC is true and correct; and I hereby authorize VDMC or their agent to verify any information on this form.

Applicant Signature _____ Date _____

Notice of Availability of Language Assistance, Auxiliary Aids, and Accessibility Services

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-800-774-4344 or speak to your provider.

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-800-774-4344 o hable con su proveedor.

中文 (Chinese)

注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-800-774-4344 或咨询您的服务提供商。

Việt (Vietnamese)

LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-800-774-4344 hoặc trao đổi với người cung cấp dịch vụ của bạn.

Srpsko-hrvatski (Serbo-Croatian)

OBAVEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-774-4344 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-774-4344).

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-800-774-4344 an oder sprechen Sie mit Ihrem Provider.

العربية (Arabic)

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها. أو تحدث إلى مقدم الخدمة 1-800-774-4344 - مجاناً. اتصل على الرقم

ລາວ (Laotian)

ເລື່ອງສຳຄັນ: ຖ້າທ່ານເວົ້າພາສາລາວ, ຈະມີບໍລິການຊ່ວຍດ້ານພາສາແບບບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ມີເຄື່ອງຊ່ວຍແລະການບໍລິການແບບບໍ່ເສຍຄ່າທີ່ເໝາະສົມເພື່ອໃຫ້ຂໍ້ມູນໃນຮູບແບບທີ່ສາມາດເຂົ້າເຖິງໄດ້. ໂທຫາເບີ 1-800-774-4344 ຫລື ມາກັບຜູ້ໃຫ້ບໍລິການຂອງທ່ານ.

한국어 (Korean)

주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-800-774-4344 번으로 전화하거나 서비스 제공업체에 문의하십시오.

हिंदी (Hindi)

ध्यान दें: यहद आप हिंदी बोलते हैं, तो आपके हलए हनि:शुल्क भाषा स ायता सेवाएि उपलब्ध ोती हैं। सुलभ प्रारूपोिंमें जानकारी प्रदान करनेके हलए उपयुक्त स ायक साधन और सेवाएँ भी हनि:शुल्क उपलब्ध हैं। 1-800-774-4344 पर कॉल करें या अपने प्रदाता से बात करें।

Français (French)

ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-800-774-4344 ou parlez à votre fournisseur.

Dutch (Pennsylvania Dutch)

LET OP: als je Nederlands spreekt, zijn er gratis taalhelpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-800-774-4344 of spreek met je provider.

ไทย (Thai)

หมายเหตุ: หากคุณใช้ ้าภาษาไทย เรามีบริการความช่วยเหลือ ้านภาษาฟรี นอกจากนี้ ยังมีเครื่องมือและ ับริการช่วยเหลือเพื่อให ้าข้อมูลในรูปแบบที่ ่อ ้าถึงได้ ้าโดยไม่เสียค่าใช้ ้าจ่าย โปรดโทรติดต่อ 1-800-774-4344 หรือปรึกษาผู้ ้าให้บริการของคุณ

Tagalog (Tagalog—Filipino)

PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-800-774-4344 o makipag-usap sa iyong provider.

ထာဝုတ်လိဝဲအိဝါ (Karen)

ဆူ- နုတ်ကတိာ် ထာဝုတ်လိဝဲအိဝါ အပိ, တာ်အိဝိဒီး ကျိ်တာ်အိဝိဝဲထဲထာ်လါတလတ် ဘျုတ်လတ်ထုလၢနုဂိ်လိဝါ. တာ်အိဝိဒီး တာ်မထာ်တာ်နုဟူပီးလိဒီး တာ်မထာ်တာ်မာ် လၢအကြးအဘျုတ် လၢကဟ့တ်တာ်ဂု်တာ်ကျိ်လၢတာ်မာ်နုအိလၢသ့တဖျုတ် လၢတလတ်ဘျုတ်လတ်ထု လၢနုဂိ်လိဝါ. ကိး 1-800-774-4344 မ့တမ့ာ် ကတိာ်တၢ်ဒီး နုပုလၢဟ့တ် နုတၢ်ကွံာ်ထဲထဲထာ်တက့ာ်

РУССКИЙ (Russian)

ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-800-774-4344 или обратитесь к своему поставщику услуг.