May 22, 2019

FINANCIAL ASSISTANCE / CHARITY CARE APPLICATION

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE: Completing this application will help Shenandoah Medical Center determine if you can receive free or discounted services or other public programs that can help pay for your healthcare. Please submit this application to the hospital. IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

Please complete this form and submit to Shenandoah Medical Center in person or by mail to apply for free or discounted care within 60 days following the date of discharge or receipt of outpatient care.

Patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining eligibility.

Instructions: COMPLETE THE APPLICATION IN FULL AND SIGN THE AUTHORIZATION TO VERIFY INFORMATION		
PATIENT INFORMATION		
Email Address		Family Size
Last Name First Name	Date of Birth	Social Security Number
Street Apt # City ST Zip Code		Home Phone
Employer Address		Cell Phone
City State Zip Code	Monthly Income	Work Phone
GUARANTOR / SPOUSE (IF RESPONSIBLE PARTY, PATIENT IF MINOR)	Relationship to Patient	Date of Birth
Email Address		
Last Name First Name		Home Phone
Employer Address		Cell Phone
City State Zip Code	Monthly Income	Work Phone

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SHENANDOAH MEDICAL CENTER

INCOME INFORMATION

Presumptive Eligibility: Uninsured patients who demonstrate one of the presumptive eligibility criteria listed below individually or through benefits provided to their family may be eligible to receive ***free care***. *Proof of Income and/or eligibility will be required*.

- ☐ WIC
- ☐ LIHEAP: Low Income Home Energy Assistance Program
- ☐ SNAP
- ☐ Community Based Medical Assistance Program
- ☐ Iowa Free Lunch/Breakfast
- ☐ Grant Assistance for Medical Services
- ☐ Incarcerated
- ☐ TANF: Temporary Assistance for Needy Families
- ☐ Homelessness
- ☐ Personal Bankruptcy
- ☐ Deceased w/ No Estate
- ☐ Affiliation with a Religious Order and Vow of Poverty
- ☐ Medicaid eligibility but not on the date of service or for Non-Covered Service
- ☐ Mental incapacitation with no one to act on patient's behalf
- ☐ Iowa Housing Development Authority's Rental Housing Support Program

Check as many as apply:

Please provide all necessary listed documentation for each member in the household, as it applies:

1. A copy of Government Issued ID (Drivers License, State ID, Military ID)
2. copy of the most recent tax return
3. Three months bank statement
4. A copy of the most recent pay stub
5. A statement from your employer if paid in cash
6. If social security income: a copy of benefits letter.

You may receive income or support from another source for example: SSA, disability, child support, alimony, unemployment or worker's compensation, veteran's pension or disability, TANF, retirement income, or other income. Please indicate the source and amount of income.

Income Source	Amount

If you cannot provide any documentation relating to your income, fill out the statement below and attach a letter of explanation:

I, ____, certify that I have no documents that prove my families

monthly income of $_________________________.

DEPENDENT HOUSEHOLD MEMBERS

Children 18yrs or younger and/or High School student
Spouse or Dependent Adult

Name	Age	Relationship
		SELF

Other Information: If you have additional documents that may help SMC make a determination regarding your application, such as large outstanding bills which would show financial hardship, please provide those documents (example: phone bills, electricity bills, medical bills, etc.). **Please note**: Revolving Credit Cards will not be considered.

APPLICANT CERTIFICATION: I certify that the information in this application is true and correct to the best of my knowledge. I will apply for state, federal or local assistance for which I may be eligible to help pay for my hospital / clinic bills. I understand that the information provided may be verified by the SMC, and I authorize SMC to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the medical bills. All information obtained in the application process will remain confidential and protected under patient's rights to privacy.

Applicant Signature: ____ Date: _______________________

In the case of incomplete applications, the applicant will be notified in writing of all required information or documentation to complete the application. The applicant will be informed that this information must be received within 30 days of the date the notification was postmarked. If the applicant does not respond with the information needed to complete the application within the 30 day timeframe, the request for assistance will be denied.

You may return your completed charity care application and documents to:

Shenandoah Medical Center
Attn: Financial Counselor
300 Pershing Ave., Shenandoah IA 51601.
For questions call the Financial Counselor at (712) 246-7201.