**FINANCIAL ASSISTANCE / CHARITY CARE APPLICATION**

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| 2024 Poverty Guidelines |
| Household Size | Poverty Guideline |
| 1 | $ 15,060.00 |
| 2 | $20,440.00 |
| 3 | $ 25,820.00 |
| 4 | $ 31,200.00 |
| 5 | $ 36,580.00 |
| 6 | $ 41,960.00 |
| 7 | $ 47,340.00 |
| 8 | $52,720.00 |
| Each additional | + $5,380.00 |

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 the entire 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.

***\*Please Note: Application is required to be completed in full in order to be considered.***

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| **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 (N/A if unemployed) Address | Cell Phone |
| City State Zip Code | Monthly Income | Work Phone |
| Primary Insurance Carrier | Secondary Insurance Carrier |
| **GUARANTOR / SPOUSE (IF RESPONSIBLE PARTY, PATIENT IF MINOR)** | Relationship to Patient | Date of Birth |
| Email Address |
| Last Name First Name | Home Phone |
| Employer (N/A if unemployed) Address | Cell Phone |
| City State Zip Code | Monthly Income | Work Phone |
| Primary Insurance Carrier | Secondary Insurance Carrier |

**INCOME INFORMATION**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Income Monthly** | **Patient** | **Spouse** | **Responsible Party** | **Children Working** |
| Gross Monthly Salary |  |  |  |  |
| Public Assistance Benefit |  |  |  |  |
| Unemployment Benefit |  |  |  |  |
| Social Security Benefit |  |  |  |  |
| Workers’ Compensation |  |  |  |  |
| Child Support |  |  |  |  |
| Other (Alimony, Pension, Life Insurance, Veterans Administration Benefits, Disability)  |  |  |  |  |
| Total  |  |  |  |  |

Total Family Income: ­­\_$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you applied for Medicaid: YES NO (circle)

DEPENDENT HOUSEHOLD MEMBERS

A dependent is a person other than the applicant or spouse who has been identified as such by the internal revenue service. The dependent must be a child 18yrs or younger and/or a High School student or a Dependent Adult as defined by the Department of Human Services. The dependent must reside with the applicant and have a familial relationship with the applicant.

|  |  |  |
| --- | --- | --- |
| Name | Age | Relationship |
|  |  | SELF |
|  |  |  |
|  |  |  |
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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. A copy of the Medicaid denial letter.
3. Copy of the tax return from the most recent tax year including all schedules, W-2s, and 1099s.
4. Three months bank statement
5. A copy of the most recent pay stub
6. If social security income: a copy of check or a copy of benefits letter.
7. If unemployed: verification of any compensation received. Example: Unemployment compensation, workers compensation.

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.

**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.