Iowa Specialty
Hospitals & Clinics

IOWA SPECIALTY HOSPITALS AND CLINICS
Financial Assistance Information Sheet

Iowa Specialty Hospital is a Community Facility providing charitable services as a nonprofit entity. We are committed to providing quality healthcare to patients by offering financial assistance to those that do not have personal resources to pay for care in emergency, non-emergency and non-elective procedures.

Financial assistance applies to all patients regardless of race, color, creed, sex, age, disability, religion, national origin, political belief, sexual preference, sexual orientation or payer that reside in the state of Iowa.

Supporting documents such as checklist below will be requested to support information reported and will be filed with completed assessment. ***We will need the same supporting documents for anyone living in your household above the age 18.***

______ Current copy of tax filing - FEDERAL & STATE

______ Proof of income (last 3 weeks of paystubs)

______ Bank statement (currently last 2 months) (Optional)

(Adequate information must be made available to determine eligibility)

______ Proof of Medicaid Denial or Acceptance

Financial Assistance must be completed with requested documentation within 30 days from the date form was given. Collection process will be held for 30 days but payments on account should not be stopped. If completed documentation is not received within 30 days, account will proceed with Iowa Specialty Hospital Collection Policy. Failure to complete the forms and provide adequate supporting data to support the information provided could disqualify the applicant from receiving Financial Assistance.

You may be receiving this application due to insufficient payments on your account with us. In order to continue to pay outside of our payment plan guidelines we respectfully request that you fill out our financial assistance application. This will help us determine the best payment plan option for you.

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IOWA SPECIALTY HOSPITALS AND CLINICS
Financial Assistance Application

<u>IMPORTANT INSTRUCTIONS</u>
It is vital this form be completed in full; along with accompanying forms and that all supporting documentation is also included when returning application.

Applicant: ____________________________

Address: ______________________________

City: _________________________________

State:______________ Zip:______________

SSN :________________ DOB: __________

Employer: _____________________________
Timing of paydays: M – W – BIWK
Hourly Wage: ______________

Spouse:________________________

Employer: _____________________

Timing of paydays: M - WK – BIWK
Hourly Wage:_________

Home phone: _____________ Number of persons in Home: _____

Age of children living at home:______________

Other Income Sources (Child Support, Alimony, Social Security Benefits, Other Household Income, etc.)

____ Amount $__________________
Month / Year

____ Amount $ __________________
Month / Year

Bank Account Balance: Checking __________ Savings ___________ Cash _____________

Client Affirmation: I affirm that the statements made herein are a true and correct to the best of my knowledge. I understand any false statements or misstatements of material fact could result in disqualification for financial assistance. I understand that I must provide verification of income, dependents, bank statements (optional) or any other information needed to complete Iowa Specialty Hospital financial assistance application.

<u>Patient Signature: ____ Date: ______________</u>