Recognizing that some individuals may not have the financial means to purchase health insurance, pay directly for healthcare services, or may be underinsured, this organization is committed to providing financial assistance through a Discounted/Sliding Fee Schedule.

CHARITY CARE/FINANCIAL ASSISTANCE GUIDELINES

1. **Availability and Use of Federal Poverty Guidelines**

   The current Federal Poverty Guidelines, as published by the Department of Health and Human Services, are made available and visible to patients at the time of service. These guidelines are reviewed during the financial assistance screening process. If the patient meets the income criteria, they will be granted charity care according to the corresponding discount percentage. At the discretion of the financial reviewer, full charity benefits may be granted if it is determined that the patient is unable to pay the portion indicated by the discount schedule, based on available resources.

2. **Proof of Income**

   The patient or guarantor will be asked to provide documentation verifying income. Acceptable documentation may include, but is not limited to:

   a. A paycheck stub from the current month
   b. A recent income tax return
   c. Other documentation demonstrating income and assets

3. **Proof of Expenses**

   The patient or guarantor may also be asked to provide proof of monthly or recurring expenses to assist in the financial evaluation.

4. **Determination of Eligibility**

   The Department of Health and Human Services Poverty Guidelines will be the primary standard used to determine eligibility for financial assistance.

5. **Final Approval**

   Final determination of eligibility and level of assistance will be made by Administration, following review of the submitted documentation and recommendations by the financial reviewer.

6. **Annual Cap on Charity Care**

   CRHC reserves the right to limit the total amount of charity care provided during each fiscal year. This limit shall be established annually and may vary based on financial and operational considerations.

7. **Proof of Public Assistance Denial**

   At the discretion of the reviewer, the patient may be required to provide proof of denial from the Department of Human Services or other applicable public assistance programs.

8. **Exceptions for Emergency Room and Clinic Patients**

   Patients applying for the Discounted/Sliding Fee Schedule through the Emergency Room or Outpatient Clinics are not required to verify assets (referenced in item #2) or provide proof of expenses (referenced in item #4).

9. **Optional Disclosure for Outpatient Clinic Patients**

   For patients utilizing outpatient clinic services, the Assets and Expenses section of the application is optional and may be omitted without impacting eligibility for assistance under the Discounted/Sliding Fee Schedule.

Please mail or return to:
Clarinda Regional Health Center
220 Essie Davison
PO Box 217
Clarinda, IA 51632

APPLICATION FOR FINANCIAL ASSISTANCE

The undersigned applicant requests that Clarinda Regional Health Center provide financial assistance and that a determination be made as to the applicant's eligibility for financial assistance based on the following information:

Patient Name: _____ Patient Date of Birth: _____

Date(s) of Service: _____

Type of Services: ☐ Inpatient ☐ Emergency ☐ Outpatient

Is Patient Covered By: ☐ Commercial insurance ☐ Medicare ☐ Medicaid

☐ Other

Guarantor (financially responsible for bill):

Name: _____ Phone number: _____

Address: _____

Street City State Zip

Employer: _____

Name(s) of dependent(s) currently residing in your household:

_____

_____

Is the Patient or Guarantor currently enrolled in college? ☐ Yes ☐ No

If yes, status: ☐ Full-Time ☐ Part-Time

FINANCIAL INFORMATION

All sources and amounts of family income must be fully disclosed and documented as part of the financial assistance application. Acceptable forms of verification include W-2 forms, current pay stubs, recent tax returns, employer-provided wage verification, or documentation from public assistance agencies. This information is essential for determining eligibility and the appropriate level of assistance.

Note: this section is optional for patients who are receiving services exclusively through outpatient clinics

Major Source: Gross Income for prior 12 months

_____ $_____

Secondary Sources – Social Security, Child Support, Public Assistance or Other:

_____ $_____

_____ $_____

_____ $_____

Total gross family income for prior 12 months $_____

Last 3 months total gross family income: $_____

Unemployed Yes ☐ No ☐ If yes, for how long? _____

Expected future income _____

Assets	**Total Value**
Checking and Savings Accounts	$_____
Stocks, Bonds, Time Certificates	$_____
Automobiles (Including leisure vehicles, boats, campers)	$_____
Property –primary home, farmland, rental property, etc.	$_____
Other	$_____
	$_____
Total Assets	$_____

Expenses/Outstanding Bills	**Balance Due, If Applicable**	**Monthly Payment**
House Payment	$_____	$_____
Rent	$_____	$_____
Utilities		$_____

Insurance –home, vehicles, health, other		$_____
Loans—homes, vehicles, other	$_____	$_____
Credit Card Payments	$_____	$_____
Medical Bills—Dentist, Doctor, Pharmacy		$_____
Other	$_____	$_____
Total Expense/Bills	$_____	$_____

Did you file a Federal Income Tax form last year? YES NO

If so, please attach a copy of the 1040 form (both front and back).

Other circumstances you feel should be considered during the review of this application:

_____

_____

_____

_____

I certify that the above information is true and correct and understand that a misrepresentation of the above statement may result in denial of financial assistance or reversal of financial assistance on prior account (s).

_____ _____

Signature of Applicant Date

For Administrative Use Only:

*Approved*_____ *Denied*_____

*Reason*_____

_____ _____

Signature of Hospital Reviewer *Date*