

FINANCIAL ASSISTANCE POLICY

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 available to patients at the time services are provided. These guidelines are used during the financial assistance screening process to determine eligibility. Patients whose household income meets the established criteria may qualify for charity care based on the applicable discount percentage. At the discretion of the financial reviewer, additional assistance, including full charity care, may be granted when it is determined that the patient is unable to pay the remaining balance based on available financial resources. *Visit www.aspe.hhs.gov for more information*

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 such as billing and utility statements to assist in the financial evaluation process.

4. Final Approval

Final eligibility decisions and the level of financial assistance awarded will be determined by Administration following review of all submitted documentation and the recommendation of the financial reviewer.

5. 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 reviewed annually and may vary based on financial and operational considerations.

6. Exceptions for Emergency Room and Clinic Patients

Patients applying for assistance through the Emergency Department or Outpatient Clinics under the Discounted/Sliding Fee Schedule are not required to verify assets or provide proof of expenses as part of the application process.

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

Application for Financial Assistance

Patient Name: _____ **Date of Birth:** _____

GUARANTOR INFORMATION *(Person financially responsible for the account)*

Name: _____ **Phone Number:** _____

Address: _____
Street City State Zip Code

VISIT INFORMATION

Dates of service: _____

Type of Services: Inpatient Emergency Outpatient

Were any of these visits related to a Motor Vehicle Accident or Work Comp injury? Yes No

Insurance coverage: Commercial Insurance Medicare Medicaid Other: _____

Have you applied for Medicaid? Yes No

EMPLOYMENT HISTORY

Employed Unemployed Retired Disabled

Name of employer	Employee	Dates employed	Status
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time
	<input type="checkbox"/> Self <input type="checkbox"/> Spouse		<input type="checkbox"/> Full-time <input type="checkbox"/> Part-time

HOUSEHOLD MEMBERS

Name	Relationship	Date of Birth	Dependent	Student
	Self			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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, Social Security letters, or documentation from public assistance agencies. This information is essential for determining eligibility and the appropriate level of assistance. *Please refer to lines 2 and 3 of the Financial Assistance Guidelines (page 1)*

INCOME PER MONTH

Wages	
Spouse wages	
Social Security	
Disability	
Public Assistance	
Child support	
Other:	
Total monthly income:	

Past 12-month gross family income _____

Expected 12-month gross family income _____

EXPENSES PER MONTH

Mortgage/rent	
Utilities (<i>electric, water, gas, trash, internet</i>)	
Insurance (<i>vehicles, health, other</i>)	
Loans (<i>vehicles, school, personal, other</i>)	
Credit card(s)	
Medical (<i>doctor, dental, pharmacy, other</i>)	
Total monthly payments:	

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

Signature of Hospital Reviewer

Title

Date