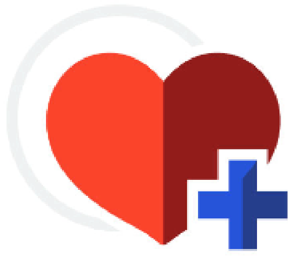

Decatur County
HOSPITAL

## Financial Assistance Program

Decatur County Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. Financial assistance will be available only to residents of Decatur County, or the immediate surrounding area consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, DCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. DCH will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for government assistance.

## Financial Assistance Available to Those Who Qualify

Decatur County Hospital has financial assistance available for those who qualify. Our Financial Assistance policy and application can be found on our website under the "Resources" tab. You need to complete an application and supply minimal financial information to establish your need. We do offer financial assistance up to 200% of the Federal Poverty Guidelines. Please call the Business Office for more information at (641) 446-4871.

In order to qualify for assistance, you must:

- Complete entire application form (the business office can help if necessary)
- Provide documentation of income for the last 12 months, including federal tax return and last three pay stubs.
- Provide evidence that you have pursued all other payment sources including public aid.
- Provide copies of bank statements.

## Request an Estimate of Charges

Decatur County Hospital's Business Office is available to help you with any questions you may have regarding your account or scheduled service. If you would like to request an estimate of charges before your visit, you may contact the Business Office at (641) 446-4871 during regular business hours of 8:00 am to 4:00 pm Monday through Friday.

The Affordable Care Act requires ***all*** hospitals to make public the hospital's standard charges for items and services provided by the hospital [Affordable Care Act, Section 2718(e) of the Public Health Service Act]. In addition, Iowa hospitals currently provide publicly-available charge information posted on www.iowahospitalcharges.com, which lets consumers make informed decisions regarding the price they choose to pay for healthcare. You may also find the link on our website under the "Resources" tab at www.decaturcountyhospital.org .

# DECATUR COUNTY HOSPITAL

Financial Assistance Application

**Patient Name:** ______________________________ **Social Security #** ______________
(Last) (First) (M)

**Patient Address:** ______________________________ **Phone:** ______________
(Street) (City) (State) (Zip)

**Head of Household:** ______________________________ **Social Security #** ______________
(Last) (First) (M)

**Annual Income:** ______________ (Gross)

**Employer:** ______________________________

**Address:** ______________________________

**Position:** ______________ **Length of Employment:** __________

**Dependents:**

| | Name | Age | Income | | Name | Age | Income |
|---|---|---|---|---|---|---|---|
| (1) | | | | (4) | | | |
| (2) | | | | (5) | | | |
| (3) | | | | (6) | | | |

**Total Number in Family:** ______________

**OTHER INCOME (Head of Household & Spouse):**

**Social Security:** ______________ **Rental Property:** ______________ **Other:** ______________

**Interest Investment:** ______________ **Child Support:** ______________ **Total Income:** ______________

**Checking Account/Balance:**

______________________________

**CD's/IRA's/Stocks & Bonds:**

______________________________

**Savings Account/Balance:**

______________________________

**Other Real Estate (Non-Homestead):**

______________________________

**Other (Personal Property, Life Insurance, etc.):**

______________________________

**OUTSTANDING DEBTS** **(include real estate & auto loans, medical debts, charge accounts, installment contracts, credit cards, utilities, etc.)**

| Name of Bank, Company, or Individual | Address | Payment Balance | Monthly Payments |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Signature—I certify that everything I have stated in this application and on any attachments is correct. You may keep this application whether or not it is approved. By signing below, I authorize you to check my credit and employment history and to answer questions others may ask you about my credit record with you. I understand that I must update credit information at your request if my financial condition changes. The falsification of data may result in the reversal of any financial assistance.**

______________________________

**(Applicant Signature)** **(Date)**

| FOR DECATUR COUNTY HOSPITAL USE ONLY | | |
|---|---|---|
| Approved % | Amount | Denied |

**Reason:** ______________________________

| Date: | Signed: | Title |
|---|---|---|