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 service area consistent with its mission to deliver exceptional care close to home, Decatur County Hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Decatur County Hospital 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, a plain language summary and application are available on our website at www.decaturcountyhospital.org or may be obtained by mail by calling (641) 446-4871. You need to complete an application and supply minimal financial information to establish your eligibility. We do offer financial assistance up to 300% of the Federal Poverty Income Guidelines. Patients eligible for financial assistance will not be charged more than the calculated amounts generally billed (AGB) by our organization. If you have any questions or need assistance to complete the application, please contact our staff per the address and phone number below.

In order to qualify for assistance, you must:

- Complete entire application form; Hospital has staff available to assist if necessary.
- Copy of most recent filed tax return.
- Provide documentation of all income sources listed on application.
- Provide copies of last 3 month's bank statements.
- Provide evidence that you have pursued all other payment sources including public aid.

Request an Estimate of Charges

Decatur County Hospital's financial services team 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 Manager at (641) 446-4871 during regular business hours of 8:00 am to 4:00 pm, Monday through Friday.

Return the financial assistance application and required attachments to:
Decatur County Hospital
ATTN: Business Office
1405 NW Church ST
Leon, IA 50144

For assistance in completing this form contact any member of the Business Office.

Decatur County Hospital
Financial Assistance Program Application

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City/State/Zip: _____ Cell Phone: _____

Email Address: _____ Work Phone: _____

Employed? ☐ Yes ☐ No Retired? ☐ Yes ☐ No

Spouse's Name: _____ Date of Birth: _____

Employed? ☐ Yes ☐ No Retired? ☐ Yes ☐ No US Citizen? ☐ Yes ☐ No

Proof of Income (A copy of ALL of the following that apply MUST be attached to this application)

☐ Federal Tax Return (most recent) ☐ 3 Mo. Bank Statements ☐ DHS/Medicaid Denials

☐ Current Pay Stub(s) (Patient, Spouse & **ALL** Other Family Members over the age of 18)

Other Income Source Documentation:

☐ Social Security ☐ VA Assistance ☐ Pension/Retirement ☐ Child Support ☐ Workman's Comp

☐ Disability ☐ Life Insurance ☐ Alimony ☐ Unemployment ☐ Public Assistance

☐ Other (please list) _____

Medical Account ASSETS

HSA/HRA Acct Values $_____ FLEX Account Values $_____

List All Other Dependents of Household PLUS Full Time Students under age 25

Name	Relationship	Birth Date	Insurance Coverage for Dependent

Attach a schedule if more space needed for additional household members.

Acknowledgements and Consents

I certify all information is true and correct to the best of my knowledge. I understand that provision of any false or misleading claims, statements, documents, or concealment of a material fact by result in the immediate cancellation of any agreement previously made. I hereby grant permission to Decatur County Hospital, its affiliates and representatives to investigate the information contained herein. By providing my wireless/cell phone number, I hereby grant Hospital and its agents my consent to use to contact me for billing, debt collection purposes and financial assistance program. I also agree to notify Decatur County Hospital of any changes in my financial position that would impact this determination.

I further consent for the disclosure of this Financial Assistance Program Application, all supporting documents and any financial assistance provided, to the following healthcare provider/organization with whom I have a relationship with and who would use such information for their respective payment activities or operations. I understand that the organization(s) identified below will make their own eligibility determination for financial assistance:

_____ _____

Organization/Provider Name City/State

_____ _____

Signature of Applicant (Date)

Contact DCH Business Office with any questions regarding this application: 641-446-4871
Mail completed form to: Decatur County Hospital; Attn: Business Office, 1405 NW Church ST, Leon, IA 50144