Financial Assistance Policy Summary and Application

Great River Health System understands there are situations when patients cannot pay for the services provided. If you need help paying for medical services, you may qualify for financial assistance from the health system.

Where to apply and how to request a copy:

- Online at https://www.greatriverhealth.org
- Request a mailed copy by calling 1-877-404-4763, option 2; 319-376-1716 or 319-385-6140
- In person. Please return completed applications to one of these locations:
  - Southeast Iowa Regional Medical Center – West Burlington Campus
    Patient Financial Services
    1221 S. Gear Avenue
    West Burlington, IA 52655
  - Southeast Iowa Regional Medical Center – Fort Madison Campus
    Business Office
    5445 Avenue O
    Ft Madison, IA 52624
  - Henry County Health Center
    Patient Financial Services
    407 S. White Street
    Mt Pleasant, IA 52641

Who is eligible?

- Insured and uninsured patients receiving medically necessary or emergency care
- Patients whose household income is between 200% and 300% of the Federal Poverty Guidelines that are updated each year.

Note

Patients without insurance who qualify for financial assistance cannot be charged more that the amount generally billed to patients who have insurance

How to apply

- Complete and sign all sections of the Financial Assistance Application on the back of this summary.
- Provide the following information:
  - Paycheck stubs from the last two months for everyone living in your household above age 18 (excluding high school students)
  - Social Security income. You can use a copy of your most recent check, bank statement, or benefits letter.
  - Most recent state and federal income tax forms
  - If you are unemployed: state unemployment claims AND final paycheck stub from your last job
  - Denial letter from the Department of Human Services (exception for rural health clinic services only)

Services covered

Inpatient services
Day Hospital
Cancer Treatment
Cardiac Rehabilitation
Cardiology
Dermatology
Digestive Health
Emergency Care
Family Medicine
Gynecology
Heart and Vascular
Home Health/Hospice
Mental Health/Psychiatry
Internal Medicine
Laboratory
Medicine Specialists
Nephrology
Neurology
Nursery
Obstetrics
Occupational Health
Ophthalmology
Orthopedics
Otolaryngology
Pediatrics
Therapy Services
Psychiatry
Podiatry
Rehabilitation
Rural Health Clinic
QuickCare
Diagnostic Imaging
Respiratory Care
Sleep Disorders
Surgical Services
Urology
Walk-in Clinic
Women's Health
Pulmonology

Financial Assistance Application

Patient Information

Name_____ Telephone_____
Address_____ Date of Birth_____Marital Status_____
City_____State_____Zip_____ Social Security Number(optional)_____

Responsible Party Information (if different from patient)	**Spouse of Responsible Party Information**
Name	Name
Address	Address
City State Zip	City State Zip
Telephone	Telephone
Date of Birth Marital Status	Date of Birth Marital Status
Social Security Number (optional)	Social Security Number (optional)

Family Members in Household

Name	Date of Birth	Relationship

Income

Source	Amount Received	How Often Received	Person Receiving
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Unemployment			
Other (Explain)			

Please describe your personal situation and your reasons for requesting assistance. This may include, but not limited to, your monthly expenses such as mortgage, child support, alimony and loans.

If your financial assistance application is showing no income at all, please descrive how you provide for your everyday living expenses such as housing, food and clothing.

I hereby acknowledge that the information given to Great River Health System is true and correct to the best of my knowledge. I hereby authorize Great River Health System to verify this information.

Responsible party signature_____ Date_____

Spouse signature_____ Date_____