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 less than 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 *(optional)*, 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 and Critical Access Hospital services only)

Services covered

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

Financial Assistance Application

Patient Information

Name________________________ Telephone________________________
Address________________________ Date of Birth ______________
City______________ State________ Zip________ Social Security Number(optional)________________

Responsible Party Information (if different from patient) / Spouse of Responsible Party Information

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 (optional)		Date of Birth	Marital Status (optional)	
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. (optional)

If your financial assistance application is showing no income at all, please describe 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________________