

## APPLICATION FOR FINANCIAL ASSISTANCE

Patient's Name: \_\_\_\_\_

### DOCUMENTATIONS REQUIRED CHECKLIST

Please be sure to return the following items to assure your application is processed:

- Completed application. Please complete **all fields**, sign and date the application. If something does not apply to your situation mark zero or N/A.
- Complete, signed Federal Tax Returns for the most recent year for applicant and all adults earning income in the household. (This includes unmarried couples.) Copies of past returns can be obtained from IRS at 800-829-1040.
  - Check here if you did not file an income tax return for last year and explain:
   
\_\_\_\_\_
   
\_\_\_\_\_
   
\_\_\_\_\_
- If you only receive social security income and do not file taxes, please send this year's Social Security Benefit statement.
- Eligibility for all other insurance and third-party payment options must be determined, including Medical Assistance (Medicaid) prior to qualifying for Financial Assistance benefits.
- Medicaid denial letter (Please see #4, next page)
- Verification of income - Last two (2) pay stubs, recent Federal Income Tax Return, most recent W-2 or 1099, Social Security Award Letter, Unemployment Statement, Workers Compensation Award Letter, Pension or Annuity Statement
- Evidence of identity - Driver's license, school identification card, voter registration card, U.S. military card or draft record, Identification card issued by federal, state or government
- Verification of residency - Utility bill, rental agreement/lease, mortgage statement, tax bill, rooms & board statement, written verification from landlord
- Copy of Property Tax Statement for all real estate owned
- Non-Mercy Iowa City outstanding medical debt
- Other supporting documents

**\*\*Please do not send original documents. They will not be returned to you. Send photocopies only or bring originals to Mercy Iowa City's Financial Counseling Office to make copies. \*\***

**Submit completed/Signed Form to:**      Mercy Iowa City, P.O. Box 3130, Iowa City, IA, 52244

1. General. All applicants, regardless of race, color, creed, religion, national origin, disability, sex, age, or status in regard to public assistance will be considered.
2. Application. Application for Financial Assistance must be submitted to the Program Coordinator along with the following:
  - a. Complete copies of most recent federal income tax return for the applicant and all adults (18+ years old) earning **income in the household**. If a person required to submit a return did not file one, or if income sources have changed since the return was filed, then that person shall submit evidence showing his/her income for the 12 months immediately preceding application. **Proof of income must be attached.**
3. Services. Emergency or medically necessary treatment services provided by Mercy Iowa City are eligible for the Financial Assistance Program including the following Mercy Iowa City entities: Services not deemed medically necessary are not eligible for the Financial Assistance benefit. Examples include: Cosmetic services, tubal reversals, semen analysis, elective surgical procedures, hearing aids.
4. Eligibility. To apply for Financial Assistance, an applicant must return the completed application with a copy of their Federal Income Tax Return for the most recent tax year. The level of Financial Assistance will be determined by the Medicaid Eligibility Team or designee. For questions, please call Iowa Medicaid at 866-572-7662.

Notice to Uninsured Applicants. Eligibility for all other insurance and third-party payment options must be determined, including Medical Assistance (Medicaid) prior to qualifying for Financial Assistance benefits. Your Medical Assistance/Medicaid denial must be included.

- All applications must be accompanied by a valid denial of benefits letter for any reason. Proof of denial must be attached. Without this paperwork, we will be unable to process your application.
5. Payments from Applicant. When an applicant is approved for partial financial assistance through the Financial Assistance Program, payment arrangements must be made and agreed upon by applicant and Mercy Iowa City for any remaining balance.
  6. Payments from Collateral Sources. All available health insurance proceeds shall be paid directly to Mercy Iowa City. If there is liability insurance, other private insurance, a lawsuit, or reimbursement available from any other source, it will be paid directly to Mercy Iowa City or arrangements will be made for direct payment, before an applicant is eligible for Financial Assistance.
  7. Right to Amend and Repeal Plan. Mercy Iowa City reserves the right to modify or repeal the Financial Assistance program, at any time, as it deems necessary.
  8. **Submit completed/Signed Form to:** Mercy Iowa City, P.O. Box 3130, Iowa City, IA 52244

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### FINANCIAL ASSISTANCE GUIDELINES

To apply for Financial Assistance, all household income included on applicable tax statements must show federal adjusted gross incomes, when combined, fall within the Guidelines set forth below. For purposes of the Guidelines, “Family Size” means the number of persons residing in applicant’s household for whom an exemption could be claimed on the federal income tax returns. Assets are also used in Financial Assistance determination.

Household income as % of FPG	Financial Assistance Discount
150% or less	100% discount
151-200%	75% discount
201-250%	50% discount
251-300%	25% discount
301% or more	No discount

INCOME BASED DISCOUNT ELIGIBILITY CRITERIA AND DISCOUNT									
Updated with the 2021 HHS Limits									
Family Size		1	2	3	4	5	6	7	8 or more
Poverty Guidelines		\$12,880	\$17,420	\$21,960	\$26,500	\$31,040	\$35,580	\$40,120	\$44,660
<b>First Tier:</b>  0 to 150% of poverty guidelines or less If a patient’s Family Income is this amount or less	If a patient’s Family Income is this amount or less, the patient will receive a discount of 100% of his/her Patient Balance Due	\$19,320	\$26,130	\$32,940	\$39,750	\$46,560	\$53,370	\$60,180	\$66,320
<b>Second Tier:</b>  Over 150% and under 201% of poverty guidelines	If a patient’s Family Income is this amount or less, the patient will receive a discount of 75% of his/her Patient Balance Due	Between \$19,320 and \$25,760	Between \$26,130 and \$34,840	Between \$32,940 and \$43,920	Between \$39,750 and \$53,000	Between \$46,560 and \$62,080	Between \$53,370 and \$71,160	Between \$60,180 and \$80,240	Between \$66,320 and \$89,320
<b>Third Tier:</b>  Between 201% and 250% of poverty guidelines	If a patient’s Family Income is this amount or less, the patient will receive a discount of 50% of his/her Patient Balance Due	Between \$25,760 and \$32,200	Between \$34,840 and \$43,550	Between \$32,940 and \$54,900	Between \$43,920 and \$66,250	Between \$62,080 and \$77,600	Between \$71,160 and \$88,950	Between \$80,240 and \$100,300	Between \$89,320 and \$111,650
<b>Fourth Tier:</b>  Over 250% up to 300% of poverty guidelines	If a patient’s Family Income is this amount or less, the patient will receive a discount of 25% of his/her Patient Balance Due	Between \$32,200 and \$38,640	Between \$43,550 and \$52,260	Between \$54,900 and \$65,880	Between \$66,250 and \$79,500	Between \$77,600 and \$93,120	Between \$88,950 and \$106,740	Between \$100,300 and \$120,360	Between \$111,650 and \$133,980

\*For families/households with more than 8 persons, add \$4,540 for each additional person.

\*Please note: The above information on the 2021 HHS Poverty Guidelines refers to the 48 contiguous states and the District of Columbia. Alaska and Hawaii have separate calculations.



An Affiliate of  
**MERCYONE.**

### APPLICATION FOR FINANCIAL ASSISTANCE

Account Number(s)

Mercy Iowa City Hospital Account(s)

\_\_\_\_\_

Mercy Iowa City Physician & Clinics Services Account(s)

\_\_\_\_\_

#### PATIENT'S HOUSEHOLD DEMOGRAPHIC AND FINANCIAL INFORMATION

I request Mercy Iowa City determine if I am eligible for Mercy Iowa City's Financial Assistance Program for my hospital and/or clinic bills based upon household income and other financial information. I understand that I am required to give certain financial information. I also understand Mercy Iowa City, or its agents may check the information for accuracy. I understand that filling out this form does not guarantee that I will receive this financial help. If I am not eligible for financial assistance, I am responsible for my health system bills.

**Please Print**

<b>Name (head of household):</b>			
	First	Middle	Last
<b>Patient's Name:</b>	<b>Date of Birth:</b>		
<b>Home Mailing Address:</b>			
<b>City:</b>	<b>State:</b>		<b>Zip:</b>
<b>Telephone # (Daytime):</b>		<b>Telephone # (Evening):</b>	

<b>Names and date of birth of Family Members living with you for which you are financially responsible</b>		
If you are living with a domestic partner and share a child, list the partner below and their financial information on the next page.		
Name	Date of Birth	Relationship to applicant

Household Income		Household Assets	
If you are living with a domestic partner and share a child, list their financial information below.			
Salary/Wages – Self	\$	Cash/Savings/Money Market	\$
Salary/Wages – Spouse/Significant Other/Partner	\$	Checking Accounts	\$
Salary/Wages – other in household	\$	Home value	\$
Alimony/ Child Support	\$	Investments, Stocks/Bonds/Etc. (including retirement)	\$
Investment Income (describe):	\$	Investment property equity (provide property tax statements for all real estate you own)	\$
Farm Income	\$	Non-Residential Property Equity	\$
Military Income	\$	LLC or business equity	\$
Social Security/ Pension/Annuity	\$	Vehicles/boats (trade in value)	\$
Public Assistance (describe):	\$	Life Insurance (cash value)	\$
Self-Employment	\$	Other:	\$
Rental Income	\$		\$
Unemployment income	\$		\$
Other income (describe):	\$		\$
<b>TOTAL INCOME</b>	<b>\$</b>	<b>TOTAL ASSETS</b>	<b>\$</b>

PLEASE NOTE: Incomplete or inaccurate applications will not be approved. Be sure to include most recent tax return, three (3) pay stubs, and/or other requested documentation.

The information given above is true to the best of my knowledge. I have provided income verification with copies of the most recent Federal Income Tax Return for all household income and any other supporting documents for income and assets. I am aware that any misstated, missing, or false information can retroactively revoke my Financial Assistance allowance. It is also understood that by signing this form I am allowing Mercy Iowa City to verify all items listed.

\_\_\_\_\_  
**Signature of Applicant/Account Guarantor**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Spouse/Partner/Person Assisting Applicant**

\_\_\_\_\_  
**Date**

**List all Employers Contributing to Household Income:**

<b>Employer's Name:</b>	Employer's Phone: (      )
Employer's Address:	
<b>Employer's Name:</b>	Employer's Phone: (      )
Employer's Address:	

**Please tell us of additional factors and special circumstances you would like us to consider during review:**


**This Section for use by Mercy Iowa City Patient Financial Services Department:**

Application Receipt Date: _____	
Applicant has been determined: <input type="checkbox"/> Eligible <input type="checkbox"/> Full <input type="checkbox"/> Partial _____% <input type="checkbox"/> Ineligible	
Total Charges Approved with this Application: \$_____	
If ineligible, reason is: <input type="checkbox"/> Unable to verify income <input type="checkbox"/> Did not apply for public assistance <input type="checkbox"/> Income exceeds guidelines <input type="checkbox"/> Unable to verify other financial information <input type="checkbox"/> Other, explain:	
Application reviewed by:	Date:
Manager approval by:	Date: