CHI Health Mercy Corning
Financial Assistance Application Form Instructions

This is an application for financial assistance at *CommonSpirit Health (NHSC approved site)*.

CommonSpirit Health provides financial assistance to people and families who meet certain income requirements. You may qualify for free care or discounted care based on your family size and income, even if you have health insurance. Assistance is provided for those patients whose family income is lower than 400% of the Federal Poverty Level Guidelines. Information on the Federal Poverty Level Guidelines can be found at http://aspe.hhs.gov/poverty-guidelines.

What does financial assistance cover? The hospital financial assistance covers appropriate hospital-based services provided by CommonSpirit Health depending upon your eligibility. Financial assistance may not cover all health care costs, including services provided by other organizations.

If you have questions or need help completing this application: You may obtain help for any reason, including disability and language assistance at: 844-286-5546

In order for your application to be processed, you must:

- □ **Provide us information about your family**
- □ **Provide us information about your family's gross monthly income (income before taxes and deductions)**
- □ **Provide documentation for family income**
- □ **Attach additional information if needed**
- □ **Sign and date the form**

Mail or fax completed application with all documentation to: Financial Assistance Center, ATTN: EES - Financial Assistance Center, P.O. Box 660872. Dallas, TX 75266-0872 Fax: 469-803-4627. Be sure to keep a copy for yourself.

To submit your completed application in person CHI Health Mercy Corning, 603 Rosary Dr, Corning, IA 50841

We will notify you of the final determination of eligibility and appeal rights, if applicable, within 30 calendar days of receiving a complete financial assistance application, including documentation of income.

By submitting a financial assistance application, you give your consent for us to make necessary inquiries to confirm financial obligations and information.

We want to help. Please submit your application promptly!

You may receive bills until we receive your information.

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Please fill out all information completely. If it does not apply, write "NA." Attach additional pages if needed.

SCREENING INFORMATION
Do you need an interpreter? □ **Yes** □ **No** *If Yes, list preferred language:*
Does the patient receive state public services such as food stamps or WIC (Women, Infants, and Children)? □ **Yes** □ **No**
Is the patient's medical care need related to a car accident or work injury? □ **Yes** □ **No**
List of CommonSpirit Health hospital(s) where you were treated:

PLEASE NOTE

- We cannot guarantee that you will qualify for financial assistance, even if you apply.
- Once you send in your application, we may check all the information and may ask for additional information or proof of income.

PATIENT AND APPLICANT INFORMATION			
Patient first name	Patient middle name		Patient last name
Date of Birth	Patient Account Numbers:		Main contact number(s) ( ) _____ ( ) _____
Person Responsible for Paying Bill	Relationship to Patient	Birth Date	Email Address: _____
Mailing Address _____ _____ City State Zip Code			
Employment status of person responsible for paying bill □ **Employed** (date of hire: _____) □ **Unemployed** (how long unemployed:_____) □ **Self-Employed** □ **Student** □ **Disabled** □ **Retired** □ **Other** (_____)			

FAMILY INFORMATION
List family members in your household, including you. "Family" includes two or more people related by birth, marriage, or adoption who live together. If a patient can claim someone as a dependent on his or her income tax return, that person would be a member of the Patient's family for purposes of this Application.
FAMILY SIZE _____ *Attach additional page if needed*

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Name	Date of Birth	Relationship to Patient	If 18 years old or older: Employer(s) name or source of income	If 18 years old or older: Total gross monthly income (before taxes):	Also applying for financial assistance?
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

All adult family members' income must be disclosed. Sources of income include, for example:
- Wages - Unemployment - Self-employment - Worker's compensation - Disability - SSI
- Child/spousal support - Work study programs (students) - Pension - Retirement Income
- Other (*please identify):*

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INCOME INFORMATION

***REMEMBER**: You must include proof of income with your application.*

You must provide information on your family's income. Income verification is required to determine financial assistance.

All family members 18 years old or older must disclose their income. Please provide proof for every identified source of income.

Examples of proof of income include:

- Last year's income tax return, including schedules if applicable; or
- A "W-2" withholding statement; or
- Current pay stubs (*3 months*); or
- Written, signed statements from employers or others; or
- Approval/denial of eligibility for unemployment compensation.

If you have no proof of income or no income, please attach an additional page with a signed statement explaining how you support basic living expenses (such as housing, food, and utilities).

ADDITIONAL INFORMATION

Please attach an additional page if there is other information about your current financial situation that you would like us to know, such as a financial hardship, excessive medical expenses, seasonal or temporary income, or personal loss.

PATIENT AGREEMENT

I understand that CommonSpirit Health may verify information by obtaining information from other sources to assist in determining eligibility for financial assistance or payment plans.

- I certify that the information I have provided is true and accurate to the best of my knowledge.
- I understand that if I do not cooperate with CommonSpirit Health in providing requested information, my application may be denied.
- I understand that the information which I submit is subject to verification by CommonSpirit Health
- I understand that additional information may be requested in order to qualify for assistance.

If you receive payment from an insurance company, workers compensation plan, or any other third party, you agree to inform the hospital of any such payment. The hospital retains its right to collect the original, full billed charges should a third party provide you with payment for the hospital's services.

_____ _____

Signature of Person Applying Date