

## **Financial Assistance Program Plain Language Summary**

Boone 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 Boone County, or the immediate surrounding service area consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Boone 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. Boone 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**

Boone County Hospital has financial assistance available for those who qualify. Our financial assistance policy is available on our website at [boonehospital.com](http://boonehospital.com) or may be obtained by mail by calling 515-433-8105. You need to complete an application and supply minimal financial information to establish your eligibility. We do offer financial assistance up to 400% 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.
- Provide a copy of most recent tax return, 3 months of bank statements, or two of the most current check stubs
- Provide documentation of at least one of the income sources listed on application.
- Provide evidence that you have pursued all other payment sources including public aid.

### **Request an Estimate of Charges**

Boone 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 Vanessa Janssen at 515-433-8105 during regular business hours of 8:00 am to 4:30 pm Monday through Friday.

Return the financial assistance application and required attachments to:

Boone County Hospital  
Financial Assistance  
1015 Union St.  
Boone, IA 50036

For assistance in completing this form contact our Financial Counselor at 515-433-8105.

**BOONE 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 **AT LEAST** one of the following proofs of income **MUST** be attached to this application)

Federal Tax Return (most recent)  3 Mo. Bank Statements  
 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) \_\_\_\_\_

**Monthly Expenses:** Mortgage/Rent \_\_\_\_\_ Utilities \_\_\_\_\_ Auto \_\_\_\_\_ Medical Ins. \_\_\_\_\_ Hospital \_\_\_\_\_  
 Medication \_\_\_\_\_ Finance Company \_\_\_\_\_ Child Support \_\_\_\_\_ Child Care \_\_\_\_\_ Food \_\_\_\_\_

**Medical Account ASSETS**  
 HSA/HRA Acct Values \$ \_\_\_\_\_ FLEX Account Values \$ \_\_\_\_\_

**Proof of State Medical Ins.**  DHS/Medicaid Denials  DHS/Medicaid Approval

**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 Boone 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 Boone 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)