Financial Assistance Program Plain Language Summary

Central Community 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. Central Community Hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Central Community 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

Central Community Hospital has financial assistance available for those who qualify. Our Financial Assistance policy and application can be found on our website under the Billing tab. You need to complete an application and supply minimal financial information to establish your eligibility. We do offer financial assistance up to 300% of the Federal Poverty Guidelines. Patients eligible for financial assistance will not be charged more than the calculated amounts generally billed (AGB) by our organization. Our financial assistance policy, a plain language summary and application are available on our website at www.centralcommunityhospital.com or may be obtained by mail by calling (1-563-245-7026). 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 the entire application form (the business office can help if necessary).
- Copy of most recent filed tax return.
- Copies of last 3 months bank statements.
- Provide documentation of all income sources listed on application.
- Provide evidence that you have pursued all other payment sources including public aid.
- Copy of photo ID of patient or guarantor.

Request an Estimate of Charges

Central Community Hospital's Business Office 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 us at (1-563-245-7026) during regular business hours of 8:00 am to 4:00 pm Monday through Friday.

Return the financial assistance application and required attachments to:
Central Community Hospital
Business Office
901 Davidson St. NW
Elkader, IA 52043

For assistance in completing this form contact us (1-563-245-7026).

Central Community Hospital
Financial Assistance Program Application

Applicant Information

Applicant Name: _____ (Last) _____ (First) _____ (Middle)

Date of Birth: _____ (MM/DD/YYYY)

Patient Address: _____ (Street)

Primary Phone: _____

US Citizen? ☐ Yes ☐ No

_____ (City) _____ (State) _____ (Zip Code)

Secondary Phone: _____

Responsible Party Information (Guarantor)

Personal

Name: _____ (Last) _____ (First) _____ (Middle)

Address: _____ (Street)

_____ (City) _____ (State) _____ (Zip Code)

Home Phone: _____ Cell: _____

Email Address: _____

Birth Date: _____ SSN: _____

Employment

Employer: _____

Address: _____ (Street)

_____ (City) _____ (State) _____ (Zip Code)

Work Ph: _____

Spouse Employer: _____

Proof of Income (A copy of ALL of the following that apply MUST be attached to this application)

☐ A copy of a photo ID must be attached of the responsible party ☐ Federal Tax Return (most recent)

☐ Current Pay Stub(s) (Responsible Party, Spouse & **ALL** Other Household Members)

Other Income Source Documentation:

☐ Social Security ☐ VA Assistance ☐ Railroad Retirement ☐ Child Support

☐ Disability ☐ Life Insurance ☐ Pension/Annuity ☐ Alimony

☐ Unemployment ☐ Workman's Comp ☐ Public Assistance ☐ Other (please list) _____

ASSETS

Cash on Hand $_____ Stocks/bonds/retirement $_____ Rental Property Income $_____

Savings Accounts $_____ Other: _____ $_____

CD's (Total Value) $_____ Other: _____ $_____

FLEX/HRA Acct Values $_____ FLEX Account Values $_____ **Total Assets:** **$**_____

List All Other Person(s) Living in the Households

Name	Relationship	Birth Date	Insurance Coverage for Dependent

Attach a schedule if more space needed for additional household members.

Consent for Release of Information

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 may result in the immediate cancellation of any agreement previously made. I hereby grant permission to Central Community Hospital, its affiliates and representatives to investigate the information contained herein. I also agree to notify the hospital of any changes in my financial position that would impact this determination.

_____ (Responsible Party Signature)

_____ (Date)

Contact Central Community Hospital Business Office (1-563-245-7026) with any questions regarding this application:
Mail completed form to: Central Community Hospital; Attn: Business Office 901 Davidson St. NW Elkader, IA 52043