# Financial Assistance/Sliding Fee Schedule and Hardship Form

Information and Instructions

Myrtue Medical Center (MMC) offers financial assistance and/or hardship payment plans to eligible individuals and families. Based on your financial need, either reduced payments or free care may be available. You may be eligible for financial assistance if you:

- Have limited or no health insurance
- Can show you have a financial need
- Are a resident of MMC's primary service area
- Have medical bills in an amount that exceeds your ability to pay, as determined by MMC guidelines

By completing the attached form, you are requesting a review of your ability to meet your financial obligation to pay your medical bills. No assistance will be given on accounts which are more than 240 days since the date of the post-discharge billing statement.

## Financial Assistance Review

### About the Application Process

1. Fill out and return the Financial Assistance form in this packet
2. Include Supporting Documents
   - ☐ A complete copy of the most recent tax return(s) for everyone in the household
   - ☐ A copy of last 3 pay check receipts or pay stub(s) for everyone in the household
   - ☐ If receiving Social Security Benefits, a copy of the letter showing the total monthly benefit before Medicare premium is deducted
3. We ask that you first explore whether you are eligible for some type of insurance benefits which would cover your care (workers' compensation, automobile insurance, government insurance programs, etc.) If you would like help pursuing these options please contact our Patient Financial Advocates at 712-340-1270.
4. If required information is not provided, the application will be returned to you for completion.
5. A Patient Financial Advocate may contact you if additional information or verification is needed.
6. After we review your completed Financial Assistance form, we will notify you of our financial assistance determination in writing, no more than 30 days from the date your application was received.
7. We can help you set up a payment plan for any remaining charges or bills which are not covered by MMC's Financial Assistance program.
8. Please send your completed form and copies of your Supporting Documents to:

   **MAIL:** Myrtue Medical Center
   Attn: Patient Financial Advocate
   1213 Garfield Avenue
   Harlan, IA 51537

   **FAX:** 712-755-4284
   **EMAIL:** pfa@myrtuemedical.org
9. If you need assistance with or have questions about any part of this form or the application process, please contact our Patient Financial Advocates at 712.340.1270.

**Financial Assistance/Sliding Fee Schedule and Hardship Form**

*If you need help to complete this form please ask to speak with our Patient Financial Advocates at 712.340.1270. Please check our website for additional information including Frequently Asked Questions, Plain Language Summary and our Financial Assistance Policy.*

Instructions for Completing this Form:
Financial Assistance will not be awarded to those who do not complete the application process.
Please fill out this section completely. Return all required documentation to Myrtue Medical Center.

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Guarantor Name (person responsible for medical bill) Guarantor Number Guarantor Birth Date

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Guarantor (person responsible for the medical bill) Relation to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other

Address: _____ City: _____ State: ___ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Current Employer: _____ Hire Date: _____ Hours Per Week: _____

Previous Employer: _____ Hire Date: _____ End Date: _____

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Other Household Income Earner Name: _____Birth Date:_____

Home Phone: _____ Cell Phone: _____

Current Employer: _____ Hire Date: _____ Hours Per Week: ____

Previous Employer: _____ Hire Date: _____ End Date:_____

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Additional Household Members (living in the household)

| Name | Birth Date | Relationship | Name | Birth Date | Relationship |
|---|---|---|---|---|---|
| | | | | | |
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## Monthly **Household** Income

| Monthly Gross Income | Self | Other Income Earner/ Household Members |
|---|---|---|
| Wages/Self-Employment | | |
| Social Security, Pension or Retirement Income | | |
| Dividends, Interest, Rents, and Royalties | | |
| Unemployment/Workers' Compensation | | |
| Alimony and Child Support | | |
| VA Assistance, Disability, Rental Assistance, Other | | |
| Total | | |

***If you do not have monthly income, please explain how you take care of your monthly expenses. Use additional pages if necessary.***

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If you do not qualify for a full discount based on the sliding fee schedule the following standard payment plan will be applied to your guarantor account balance.

Standard Payment Plan Outline

| Patient Responsibility Balance | Minimum Monthly Payment | Maximum # of Payments |
|---|---|---|
| $8.00-$100.00 | $25.00 | 4 |
| $101.00-$300.00 | $30.00 | 10 |
| $301.00-$500.00 | $50.00 | 10 |
| $501.00-$750.00 | $75.00 | 10 |
| $751.00-$1,000.00 | $100.00 | 10 |
| $1,000.00-$1,500.00 | $125.00 | 12 |
| $1,501.00-$2,000.00 | $150.00 | 13 |
| $2,001.00-$2,500.00 | $175.00 | 14 |
| $2,501.00-$3,000.00 | $200.00 | 15 |
| $3,001.00-$3,600.00 | $225.00 | 16 |
| $3,601.00-$4,250.00 | $250.00 | 17 |
| $4,251.00-$5,000.00 | $275.00 | 18 |
| $5,001.00-$5,700.00 | $300.00 | 19 |
| $5,701.00-$6,500.00 | $325.00 | 20 |
| $6,501.00-$7,350.00 | $350.00 | 21 |
| $7,351.00-$8,250.00 | $375.00 | 22 |
| $8,251.00-$9,200.00 | $400.00 | 23 |
| $9,201.00+ | Determined individually | |

## Hardship Review (Only need to fill out the sections below if applying for Hardship review)

If you cannot make the standard payment plans above and would like to be considered for a non-standard payment plan based on your financial situation, please complete the rest of the financial information below for a Hardship review. Hardship review will not reduce your outstanding balance but if you qualify it can extend the time you have to pay off that balance.

## Monthly **Household** Expenses

| Expense | Amount | Expense | Amount |
|---|---|---|---|
| Rent/Mortgage | | Auto Insurance | |
| Property Taxes (if separate from mortgage) | | Vehicle Fuel | |
| Homeowner's Insurance (if separate from mortgage) | | Cell Phone | |
| Cable/Phone/Internet | | Renter's Insurance | |
| Utilities | | Childcare/Schooling (P-12) | |
| Groceries | | Child Support/Alimony | |
| Medical Expenses | | Other (please explain) | |
| Health Insurance Premiums | | Family/Personal Items | |

## **Household** Assets

| Household Member Name | Checking | Savings | CDs/IRAs | Stocks/Bonds/Mutual Funds |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

| Household Member Name | Vehicles Year/Make/Model Value | Real Estate Primary/Rental/Agricultural Value | Health Savings/Flex Spending | Other |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

## Household Liabilities

| Household Member Name | Credit Cards | | Personal Loans | | Student Loans | | Taxes Payable | |
|---|---|---|---|---|---|---|---|---|
| | Balance | Mo Pmt | Balance | Mo Pmt | Balance | Mo Pmt | Balance | Mo Pmt |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

| Household Member Name | Vehicles | | Real Estate | | Other Medical Expenses | | Other | |
|---|---|---|---|---|---|---|---|---|
| | Balance | Mo Pmt | Balance | Mo Pmt | Balance | Mo Pmt | Balance | Mo Pmt |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Additional Information: Please use this space to provide additional information regarding any items entered above (insurance policy names/numbers, additional expenses/assets/liabilities, etc.) This space may also be used to explain any situation we should be informed of in order to understand your inability to pay the outstanding medical balance. Attach a separate sheet if more space is needed. Additional verification may be required.

Authorization: I hereby acknowledge that the information given to Myrtue Medical Center is true and correct. If any information is determined to be incorrect, previous discounts will be reversed and reinstated back to the account as balance due.

Guarantor Signature: _____ Date: _____

*Signatures of Any Additional Person(s) in the Household over the Age of 18:*

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____

| *For Myrtue Medical Center Use Only* | | |
|---|---|---|
| Date Received: | Reviewed by: | Date Reviewed: |
| | | |
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