Guthrie County Hospital Sliding Fee Application

This Sliding Fee Discount Program Application is being provided to you for completion so that we can determine if you qualify for discounted medical services.

COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Sliding Fee Discount Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact the Revenue Cycle Manager at 641-332-3870.

To determine if you qualify for our Sliding Fee Discount Program, please return the following supporting documentation with the completed packet:

- A copy of a photo ID (state driver's license/state ID) or other identification documents (Social Security card, alien registry card, birth certificate, baptismal or marriage certificate, passport, visa, employee ID card, etc.).
- Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- Last two weeks of paystubs with year-to-date totals, or last two months of paystubs without year-to-date totals (if paid in cash without paystubs, provide written verification from employer)
- Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, wage and earning statement from Social Security office, etc.
- If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter, a copy of your monthly Social Security check, or copies of bank statements from three months prior showing direct deposit of the Social Security benefit.

❖ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.
❖ NOTE: Where parents of a minor patient are divorced or separated but share responsibility for the minor's medical care, each parent must complete a separate application.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided. Your completed application and supporting documentation may be submitted to:

- **Hand-delivering to the Front Desk of Guthrie County Hospital at 710 N 12th St Guthrie Center, IA 50115**
- **Mailing to:**
  Guthrie County Hospital
  Attn: Revenue Cycle Manager
  710 N 12th Street
  Guthrie Center, IA 50115

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(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Phone # (_____) _____ _____

List family members (including parents, patient, and natural or adoptive siblings) living at the above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan.		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

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III. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer _____ Unemployed (Y/N) ____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____)_____ Does Employer Offer Health Insurance? (Y/N)_____

Occupation/Position _____ Date of Hire _____

Student (Y/N) _____ Name of School _____ Number of Credits This Semester _____

MOTHLY SALARY:

Gross: $_____ Net: $_____ Hourly Pay: $_____ Hours Worked Weekly: _____

Additional Source(s) of Income (per month):

❑ Other Wages	$_____	❑ Child Support	$_____	❑ Farm Income	$_____
❑ Interest, Dividends	$_____	❑ Retirement	$_____	❑ Self-Employment	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ SSI/Social Security	$_____
❑ Alimony	$_____	❑ Unemployment	$_____	❑ Veterans Benefits	$_____
				❑ Other	$_____

Employment information of spouse (if applicable):

Spouse's Employer _____ Unemployed (Y/N) ____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____)_____ Does Employer Offer Health Insurance? (Y/N)_____

Occupation/Position _____ Date of Hire _____

Student (Y/N) _____ Name of School _____ Number of Credits This Semester_____

MOTHLY SALARY:

Gross: $_____ Net: $_____ Hourly Pay: $_____ Hours Worked Weekly: _____

Additional Source(s) of Income (per month):

❑ Other Wages	$_____	❑ Child Support	$_____	❑ Farm Income	$_____
❑ Interest, Dividends	$_____	❑ Retirement	$_____	❑ Self-Employment	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ SSI/Social Security	$_____
❑ Alimony	$_____	❑ Unemployment	$_____	❑ Veterans Benefits	$_____
				❑ Other	$_____

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IV. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state, or local assistance for which I may be eligible to help pay for my medical care. I understand that the information provided may be verified by Guthrie County Hospital. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for the sliding fee discount program, and any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____ Date of Request _____

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To ensure timely processing, please be sure to include all the required information from the checklist on the first page of this application.

OFFICE USE ONLY

Patient Name:_____

VERIFICATION CHECKLIST	YES	NO	N/A
Identification: Driver's License, Employment ID, Passport, etc.			
Income: Prior year tax return, pay stubs, bank statements			
Insurance: Insurance Cards if applicable			

Family Size _____

Patient Income _____ Spouse Income _____ Total Income _____

Poverty Level _____ Discount Available _____

Approved by: _____

Date Approved: _____