MYRTUE
Medical Center

Financial Assistance/Sliding Fee Schedule Application
Information and Instructions

Myrtue Medical Center (MMC) offers financial assistance 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
- Provide MMC with necessary information about your family finances
- Have medical bills in an amount that exceeds your ability to pay, as determined by MMC guidelines

By completing the attached application, 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.

About the Application Process

1. Fill out and return the Financial Assistance Application form in this packet
2. Include Supporting Documents
   - ☐ A complete copy of the most recent tax return(s) for everyone in the family
   - ☐ A copy of last 3 pay check receipts or pay stub(s) for everyone in the family
   - ☐ 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 712-755-4528 or 712-755-4324.
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 Application, 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 with a third party vendor.
8. Filing Your Application: Please send your completed application 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 application process, please contact our Patient Financial Advocates at 712-755-4528 or 712-755-4324.

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If you need help to complete this form please ask to speak with our Patient Financial Advocates at 712-755-4528 or 712-755-4324. 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.

PART A: Please fill this out this section completely. **PART B:** Return all required documentation to Myrtue Medical Center.

PART A:

Patient Name **Account Number** **Birth Date**

Main Contact Person: _____ Relation to Patient: ☐ Self ☐ Spouse/Partner ☐ Parent ☐ Other

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

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Social Security Number: _____(Optional)

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

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

Spouse Name: _____ Social Security Number: _____

Birth Date: _____ Home Phone: _____ Cell Phone: _____

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

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

Additional Family Members (living in the household)

Name	Birth Date	Relationship	Name	Birth Date	Relationship

Monthly Family Income

Monthly Gross Income	Self	Spouse and/or Other Family 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		

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

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.

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	

If you cannot make the standard payment 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.

Monthly Family Expenses

Expense	Amount	Expense	Amount
Rent/Mortgage		Auto Insurance	
Cable/Phone/Internet		Health Insurance	
Cell Phone		Homeowner's Insurance (if separate from mortgage)	
Utilities		Renter's Insurance	
Groceries		Childcare	
Medical Expenses		Child Support/Alimony	
Vehicle Fuel		Other Medical Bills	
Family/Personal Items		Other	

Family Assets

Family Member Name	Checking	Savings	CDs/IRAs	Stocks/Bonds/Mutual Funds

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

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Family Liabilities

Family Member Name	Credit Cards		Personal Loans		Student Loans		Taxes Payable	
	Balance	Mo Pmt	Balance	Mo Pmt	Balance	Mo Pmt	Balance	Mo Pmt
Family Member Name	**Vehicles**		**Real Estate**		**Other**		**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. I authorize Myrtue Medical Center to verify any or all information given and to obtain a consumer credit report, to be obtained as deemed necessary.

Main Contact 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:

Form. 8/16 kh, 7/19 ka; 2/20 kh