301 N. Hwy 21
P.O. Box 548
Pilot Knob, MO 63663-0848
Phone: (573) 546-1260
Fax: (573) 546-1270
www.icmedcenter.org

Dear Patient/Guarantor,

If you wish to apply for financial assistance, you will be required to provide the following information in order for us to determine your eligibility. **DO NOT RETURN THIS APPLICATION WITHOUT THESE REQUIRED DOCUMENTS**:

☐ **COMPLETED IRON COUNTY MEDICAL CENTER FINANCIAL ASSISTANCE APPLICATION FORM**

☐ **DOCUMENTATION TO SUPPORT FAMILY SIZE AND ANNUAL INCOME:**
This may include all pages of your tax return, schedule and forms. If you did not file a return we will request that you contact the IRS at 1-800-829-1040 and request a verification of non-filing for the previous two years.

☐ **PROOF OF CURRENT INCOME:**
Last 3 months of pay stubs (or a letter from your employer if paid in cash).
Last 3 months of ALL savings and checking accounts. Report all CDs, Stocks, Bonds, IRAs, etc.
Statement of child/alimony support.
Retirement or pension letter.
If you are drawing Social Security, please enclose a copy of the last letter you received from Social Security stating your check amount for the coming year.

☐ **DETERMINATION APPLICATION or DENIAL FROM MO HEALTHNET (Medicaid):**
You MUST apply for Medicaid before this application will be processed. Submit your approval/denial letter.
To apply call 855-373-9994 or go to mydss.mo.gov

Your information must be returned within thirty days. We will not be able to process your application without ALL the information. If you do not have all the requested information, please call the Financial Counselor at 573-546-8025 for instructions. Failure to comply will result in automatic denial.

You may qualify for full or partial assistance on your open accounts with Iron County Medical Center. Consideration for assistance is based on your financial status in comparison with the Federal Income Guidelines. This assistance program is separate from any other provider or government agency.

All other sources of payment must be used before financial assistance is approved. Examples of payments would be all medical insurance, Medicare, Medicaid, third party and/or liability claims.

Please see attached guidelines to see if your monthly income and family size would qualify you for assistance.

2023 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES - PERSONS IN FAMILY/HOUSEHOLD POVERTY GUIDELINE
DISCOUNTS RANGE FROM 40% - 100% DEPENDING ON FINAL CALCULATIONS:

1	$29,160 ---- (est) $58,000
2	$39,440 -–– (est) $79,000
3	$49,720 -–– (est) $99,000
4	$60,000 – (est) $120,000
5	$70,280 – (est) $140,000
6	$80,560 – (est) $161,000
7	$90,840 – (est) $182,000
8	$101,120 – (est) $202,000

For Families/Households with more than 8 persons, add $10,280 for each additional

Patient / Insurance Information

Patient Name: ____ Date of Birth: _____________________

Address: ____ Phone: ____________________________

Social Security # _____________________________________ Number in Your Household: ___________________________

Employer: ____ How long employed? _________________________

If unemployed, name of last employer: ______________________________________ How long ago? _________________

1. Are you a U.S. citizen? ____ Yes ____ No

2. Do you have dependents under the age of 18 living at home? ____ Yes ____ No

3. Do you have health insurance coverage available? **YES** **NO**

If **yes**, why do you require financial assistance? ____

If **no**, please indicate reason for lack of coverage: ____

Have you applied for Medicaid? YES NO **---THIS IS A REQUIREMENT FOR THIS APPLICATION**

Date applied: ________________ If denied, date: _____________ Reason for denial: _______________________________

Family Income Information

Wages (total gross) $ ____

Social Security Earnings $ ____

Food Stamps $ ____

Unemployment $ ____

Retirement / Pension $ ____

Dividends and Interest $ ____

Alimony / Child Support $ ____

Other Income $ ____

I do certify that the information provided above is true and accurate.

____ _______________________________

Patient Signature Date

Family / Household Members

LIST ALL HOUSEHOLD MEMBERS

Name	Age	Relationship To Patient
1		
2		
3		
4		
5		
6		
7		
8		

If you have any questions about this application, please contact the Financial Counselor's office at 573-546-8115.

Please make sure ALL required documents listed on the front are attached when submitting your application or you will be declined.

I certify that the information provided in connection with this Financial Assistance Application is correct and complete. I authorize verification of any information and I understand that additional documentation may be requested. If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever legal action becomes appropriate.

Patient/Guarantor Signature: ____ Date: ________________