



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).

-Statement of child/alimony support.

-Retirement and/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.

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 573-546-8115 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 review attached guidelines to see if your monthly income and family size would qualify you for assistance. Discounts are by household number and range from 25% - 100% depending on final calculations.

Federal Poverty Guidelines for the State of Missouri 2026 2026 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
1	\$31,920 -- \$63,840
2	\$43,280 -- \$86,560
3	\$54,640 -- \$109,280
4	\$66,000 -- \$132,000
5	\$77,360 -- \$154,720
6	\$88,720 -- \$177,440
7	\$100,080 -- \$200,160
8	\$111,440 -- \$222,880
9	\$122,800 -- \$245,600
10	\$134,160 -- \$268,320

For Families/Households with more than 10 persons, add \$11,360 for each additional

Patient / Insurance Information

Patient Name: _____ Date of Birth: _____

Address: _____ Phone: _____

Social Security # (optional) _____ Number in Your Household: _____

Employer: _____ How long employed? _____

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

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

2. 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: _____

Family Income Information

Wages (total gross) \$ _____

Social Security Earnings \$ _____

Food Stamps \$ _____

Unemployment \$ _____

Retirement / Pension \$ _____

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		
9		
10		

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. If you cannot provide the required information, please tell us why you are unable to do so:

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: _____