Financial Assistance Program Plain Language Summary

MercyOne Elkader Medical Center is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. MercyOne Elkader Medical Center strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. MercyOne Elkader Medical Center will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for government assistance.

Financial Assistance Available to Those Who Qualify
MercyOne Elkader Medical Center has financial assistance available for those who qualify. Our Financial Assistance policy and application can be found on our website under the Billing tab. You need to complete an application and supply minimal financial information to establish your eligibility. No one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available based on family size and income. We do offer financial assistance up to 300% of the Federal Poverty Guidelines. Patients eligible for financial assistance will not be charged more than the calculated amounts generally billed (AGB) by our organization.

Our financial assistance policy, a plain language summary, application, and a list covered providers and groups are available on our website at mercyone.org/elkader or may be obtained by mail by calling (1-563-245-7026). If you have any questions or need assistance to complete the application, please contact our staff per the address and phone number below.

In order to qualify for assistance, you must:

- Complete the entire application form (the business office can help if necessary).
- Copy of most recent filed tax return.
- Provide documentation of all income sources listed on application.
- Provide evidence that you have pursued all other payment sources including public aid.
- Copy of photo ID of patient or guarantor.

Request an Estimate of Charges
MercyOne Elkader Medical Center's Financial Counselors are available to help you with any questions you may have regarding your account or scheduled service. If you would like to request an estimate of charges before your visit, you may contact us at (1-563-245-7026) during regular business hours of 8:00 a.m. to 4:00 p.m. Monday through Friday.

Return the financial assistance application and required attachments to:

MercyOne Elkader Medical Center
Business Office
901 Davidson St. NW
Elkader, IA 52043

For assistance in completing this form contact us (1-563-245-7026).

MercyOne Elkader Medical Center
Financial Assistance Program Application

Applicant Information

Applicant Name: ____________________ (Last) (First) (Middle)

Date of Birth: ____________________ (MM/DD/YYYY)

Patient Address: ____________________ (Street)

____________________ (City) (State) (Zip Code)

Primary Phone: ____________________

Secondary Phone: ____________________

Responsible Party Information (Guarantor)

Personal

Name: ____________________ (Last) (First) (Middle)

Address: ____________________ (Street)

____________________ (City) (State) (Zip Code)

Home Phone: ____________________ Cell: ____________________

Email Address: ____________________

Birth Date: ____________________

Employment

Employer: ____________________

Address: ____________________ (Street)

____________________ (City) (State) (Zip Code)

Work Ph: ____________________

Spouse Employer: ____________________

Proof of Income (A copy of ALL of the following that apply MUST be attached to this application)

☐ A copy of a photo ID must be attached of the responsible party

☐ Federal Tax Return (most recent)

☐ Current Pay Stub(s) (Responsible Party, Spouse & **ALL** Other Household Members)

List All Other Person(s) Living in the Households

Name	Relationship	Birth Date	Insurance Coverage for Dependent

Attach a sheet if more space needed for additional household members.

Consent for Release of Information

I certify all information is true and correct to the best of my knowledge. I understand that provision of any false or misleading claims, statements, documents, or concealment of a material fact may result in the immediate cancellation of any agreement previously made. I hereby grant permission to MercyOne Elkader Medical Center, its affiliates, and representatives to investigate the information contained herein. I also agree to notify the hospital of any changes in my financial position that would impact this determination.

____________________ (Responsible Party Signature)

____________________ (Date)

Contact MercyOne Elkader Medical Center at (1-563-245-7026) with any questions regarding this application or for a list of providers or groups covered under this application. Mail completed form to: MercyOne Elkader Medical Center; 901 Davidson St. NW, Elkader, IA 52043