Greene County MEDICAL CENTER
Always Here, Always Caring

An Affiliate of UnityPoint Health

FINANCIAL ASSISTANCE APPLICATION

Thank you for inquiring about the Financial Assistance program at Greene County Medical Center. Please fill out the attached application and return it with the required documentation below within 30 days. If your completed application has not been received within the specified time, your account will be subject to our standard billing procedures. When Greene County Medical Center has received your completed application, it will be reviewed to determine your level of qualification. You will be notified of our determination within 30 days of receipt.

Applicants are required to apply for Medicaid before financial assistance through the medical center will be considered. If you would like assistance completing your Iowa Medicaid application, or this application, please contact our Financial Counselor, at (515) 386-0278. They are located in the Business Office at the medical center and will also be available to discuss other financial assistance options for which you may qualify.

Along with the completed application, copies of the following documents are also required. Any application returned without a signature or the appropriate documentation will not be considered.

Documentation check list: *PLEASE DO NOT SEND ORIGINALS*

- ☐ Last filed Federal Income Tax Return
- ☐ Three (3) consecutive months of proof of income (pay-check stub, letter from employer)
- ☐ Three (3) consecutive months of last statement for: checking, savings, stocks, bonds, CDs, 401k, IPERS, life insurance
- ☐ Proof of DHS (Medicaid) application; Notice of decision (if applicable)

PLEASE NOTE THAT ELECTIVE PROCEDURES MAY NOT BE CONSIDERED FOR ASSISTANCE.

- ☐ I certify all information on this application is true and correct to the best of my knowledge. I understand that provision of any false or misleading information or concealment of a material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Greene County Medical Center to contact the organizations listed on this application to verify information given on this application.

Applicant Signature: _____Date:_____

UNSIGNED APPLICATIONS WILL NOT BE REVIEWED FOR ASSISTANCE

APPLICATION FOR FINANCIAL ASSISTANCE:

STEP 1: COMPLETE INFORMATION BELOW: (ALL QUESTIONS MUST BE ANSWERED)

PATIENT NAME:	SOCIAL SECURITY # (REQUIRED):
ADDRESS, CITY, STATE, ZIP:	BIRTH DATE:
HOME PHONE #:	CELL PHONE #:
EMPLOYER NAME & ADDRESS:	EMPLOYER PHONE#:
# OF HOURS WORKED PER WEEK:	GROSS MONTHLY WAGE:
MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED SEPARATED WIDOWED	

NAME OF THOSE IN THE **HOUSEHOLD**	SEX	SS#	D.O.B	RELATION TO PATIENT	MONTHLY GROSS WAGES	EMPLOYER NAME	EMPLOYER PHONE NUMBER

CHECKING ACCOUNT **YES / NO**	BALANCE:	SAVINGS ACCOUNT **YES / NO**	BALANCE:
STOCKS, BONDS, IRA, CD, **YES / NO**	BALANCE:	4O1K, IPERS **YES / NO**	BALANCE: CASH VALUE:

DO YOU HAVE LIFE INSURANCE FOR YOU OR ANY DEPENDANT OVER 21 WITH A CASH VALUE? **YES / NO** **CASH IN VALUE:**	DO YOU CURRENTLY OWN, OR ARE YOU BUYING REAL ESTATE PROPERTY: **YES / NO**

PERSONAL PROPERTY: PLEASE LIST ALL CARS, TRUCKS, MOTORCYCLES, CAMPERS, OR ANY OTHER RECREATIONAL OR NON-RECREATIONAL VEHICLES. IF MORE SPACE IS REQUIRED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER.

ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:
ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:
ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:

- If unemployed, provide the date employment ended_____. Have you applied for unemployment? **YES / NO**
- If there is no reported income, have you applied for disability? **YES / NO** Are you planning on applying? **YES / NO**
- Have you applied for Medicaid? **YES / NO** Date applied**_____.**
- Did the applicant have insurance at the time of this visit? **YES / NO If yes, please fill out the following information:**

NAME OF INSURANCE:	**EFFECTIVE DATE:**
NAME OF POLICYHOLDER:	**POLICY NUMBER:**

GROSS MONTHLY HOUSEHOLD INCOME:

WAGES	
SOCIAL SECURITY	
CHILD SUPPORT	
ALIMONY	
PUBLIC ASSISTANCE**	
FOOD STAMPS **	
PENSION/ COMPENSATION	
INTEREST/ DIVIDENDS	
UNEMPLOYMENT	
OTHER	
TOTAL	

ADDITIONAL INFORMATION OR COMMENTS:

Greene County Medical Center Financial Assistance Policy
Plain Language Summary - 2025

Greene County Medical Center offers Financial Assistance to patients who have health care needs and need assistance paying for care. Financial Assistance is the cost of providing free or discounted care to individuals who qualify. This is a summary of the medical center's Financial Assistance Policy (FAP).

Availability of Financial Assistance

You may be eligible for Financial Assistance and meet eligibility requirements discussed below. The medical center provides Financial Assistance for medically necessary procedures only. Optional services, such as cosmetic, will not receive Financial Assistance. Financial Assistance is approved for a 12-month period. Once a patient's assistance expires, they are required to reapply.

Eligibility Requirements

Total income of the people living in the home is used to determine qualification. Example: If your income is at or below 175% of the Federal Poverty Income Guideline (FPIG), you may receive a 100% discount. The amount that a patient is expected to pay and the amount of Financial Assistance offered depends on the patient's insurance coverage, income, and assets. Patients that qualify for Financial Assistance will not pay more than the amounts generally billed for their emergency or medically necessary care. Please refer to the medical center's full Financial Assistance Policy for a complete explanation and details.

Financial Assistance Discount:	**100%**	**80%**	**60%**	**40%**	**20%**
%FPIG	**175%**	**200%**	**225%**	**250%**	**275%**
1	27,388	31,300	35,213	39,125	43,038
2	37,013	42,300	47,588	52,875	58,163
3	46,638	53,300	59,963	66,625	73,288
4	56,263	64,300	72,338	80,375	88,413
5	65,888	75,300	84,713	94,125	103,538

 # in Household

Household Income

Where to Find Information

There are different ways to find information about the FAP application process or get copies of the FAP and application. To apply for Financial Assistance you may: Download the information online at www.gcmchealth.com, get a copy at outpatient, ED, and Rehab registration areas, or request the information by mail, free of charge, by contacting the medical center's Patient Financial Counselor at (515) 386-0278.

How to Apply

You will need to fill out a Financial Assistance form. Applicants may be required to apply for Medicaid before Financial Assistance through the medical center will be considered. If you need help with the form, you may contact the Patient Financial Advocate at the number listed above. Return completed application with necessary documents to the Business Office or mail to: Business Office, 1000 West Lincoln Way, Jefferson, IA 50129.

Availability of Translations

The Financial Assistance Policy, application form, and Plain Language Summary are also offered in Spanish. Greene County Medical Center may elect to use a qualified bilingual interpreter by request. For information about the translation of the medical center's Financial Assistance forms, please go to www.gcmchealth.com.