Financial Assistance Application

UnityPoint Health® knows there are times when our patients cannot pay for the services provided. If you need help paying for medical services, you may be eligible for financial assistance.

Iowa / Illinois

To see if you qualify for financial assistance, please carefull follow the instructions inside.

UnityPoint Health

How to Qualify for Financial Assistance

Important: YOU MAY BE ABLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help UnityPoint Health determine if you can receive free or discounted services or other public programs that can help pay for your healthcare.

Be sure to give full information for everyone living in your home and complete all three sections on the right side of the form. If you don't return complete information, your request can not be processed. All information will be kept private.

If you already receive help from a state program (like Food Stamps or WIC), fill out the first page of t application and send it in with proof that you are in one of these programs, such as a notice of decision. Also, be sure to sign the last page of the application. You may qualify for automatic participation in our program.

By submitting this application, the patient acknowledges that he or she has made a good faith effort to provide all information requested in the application to assist the hospital in determining whether the patient is eligible for financial assistance

Providing your Social Security Number Information

IF YOU ARE UNINSURED, A SOCIAL SECURITY NUMBER IS NOT REQUIRED TO QUALIFY FOR FREE OR DISCOUNTED CARE. However, a Social Security Number is required for some public programs, including Medicaid. Providing a Social Security Number is not required but will help the hospital determine whether you qualify for any public programs.

When to Submit your Financial Assistance Application

Please complete this form and submit to the hospital in person, by mail, by electronic mail, or by fax to apply for free or discounted care within 90 days following the date of discharge or receipt of outpatient care. NOTE: The requirement to complete and submit this form within 90 days following the date of discharge or receipt of outpatient care may be increased by the hospital, but not decreased.

How to Submit your Application

Please submit this application one of the following ways:

- If by mail, to the following address:

  UnityPoint Health Financial Assistance
  PO Box 809330
  Chicago, IL 60680-9330

- If by email, to: FA_CBO_Request@unitypoint.org.
- If by fax, to: (515) 381-7166. Write "FA Application" on the fax cover sheet.

Assistance with Completing the Application

We can help with this form if you have questions.

- If you are in the hospital, ask for someone in Patient Registration to help you.
- If you are at home or in the clinic, call (833) 874-4243.

Additional Important Notes

Our team members may try to find out if you qualif for other federal or state assistance programs prior to processing your request for financial assistance fro UnityPoint Health.

Financial assistance is only available for medically necessary services provided by UnityPoint Health organizations and physicians, as outlined in our Financial Assistance Policy. If you would like to learn more about this policy, visit unitypoint.org/FAP. If you have more questions about your bill, please call the phone number listed on the bill to talk to the hospital, clinic, or home care that provided the care.

Complete All Three Sections

1. *Send complete information and remember to sign the form:*

Fill the attached form out completely. Please remember to sign the bottom of the last page. (NOTE: There is a consent statement for Iowa and a separate one for Illinois.) You only need to fill ou one form for everyone living in your home.

2. *Proof of Income for everyone in your home:*

Send copies of all items listed below that apply.

- ☐ Tax return for last year
- ☐ If you are employed: a pay stub with year-to-date income OR your last 3 pay stubs
- ☐ If you are self-employed: balance sheet and income statement
- ☐ If you are unemployed: state unemployment claim AND final pay stub from last jo
- ☐ If you are paid in cash: written income verification is required from employe
- ☐ Monthly pension amount letter
- ☐ Disability income amount letter
- ☐ Social security income amount letter
- ☐ Proof of income from rent
- ☐ Proof of income from child support
- ☐ Proof of income from alimony
- ☐ If you have NO income, written statement from the person who supports you

3. *Provide Proof of Assets for everyone in your home:*

Send copies of all items listed below that apply.

- ☐ Bank statements from the last 3 months
- ☐ Investment statements (401K, IRA, investment account, health savings account)

NOTE: Investment statements are only needed if you received care from a UnityPoint Health facility in Iowa.

Financial Assistance Application

You may experience a delay in the processing of your application if all information is not provided.

- ☐ Proof of ALL income in household for those over 21 years of age
- ☐ 3 months of bank statements, checking/savings, include ALL pages
- ☐ Last year's 1040 tax return with ALL schedules

PATIENT INFORMATION

Name _____
(Last) (First) (MI)

Address _____
(Street)

_____
(City) (State) (Zip)

Telephone _____

Email _____

Birthday _____ Age _____

Soc.Sec.No. _____ Marital Status ☐ Y ☐ N

Race (optional):

☐ American Indian or Alaska Native ☐ Asian

☐ Black or African American

☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity (optional): _____

Sex (optional): ☐ M ☐ F ☐ Other _____

Preferred Language (optional): _____

PERSON RESPONSIBLE FOR PAYMENT

Name _____
(Last) (First) (MI)

Address _____
(Street)

_____
(City) (State) (Zip)

Telephone _____

Email _____

Birthday _____ Age _____

Soc.Sec.No. _____ Marital Status ☐ Y ☐ N

Personal Employment:

Employer _____

Address _____
(Street)

_____
(City) (State) (Zip)

Telephone _____

Job Title _____

Job Status: ☐ PT ☐ FT Avg weekly hours _____

SPOUSE OF PERSON RESPONSIBLE FOR PAYMENT

Name _____
(Last) (First) (MI)

Address _____
(Street)

_____
(City) (State) (Zip)

Telephone _____

Email _____

Birthday _____ Age _____

Soc.Sec.No. _____ Marital Status ☐ Y ☐ N

Personal Employment:

Employer _____

Address _____
(Street)

_____
(City) (State) (Zip)

Telephone _____

Job Title _____

Job Status: ☐ PT ☐ FT Avg weekly hours _____

OTHER INFORMATION

List All Other People Living in the Household:

Name Relationship Soc. Sec. No. Birthdate

_____

_____

_____

_____

_____

Second Employer for Responsible Party and/or Spouse:

Employer _____

Address _____
(Street)

_____
(City) (State) (Zip)

Telephone _____

Job Title _____

Job Status: ☐ PT ☐ FT Avg weekly hours _____

All columns must be completed.

UnityPoint Health

INCOME

Source of Income *(must provide documentation)*	Amount Received	How Often Received	Name of Person Receiving
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Comp/Unemployment			
Interest/Dividend			
Other (Explain)			

ASSETS

Item	Acct Balance	Description	*Provide 3 months of statements
Checking Account*			
Savings Account*			

Complete this additional list only if you received care from a UnityPoint Health facility in Iowa

Item	Current Value	Description
401(K)/IRA/Health Savings Account		
Main Home (assessed value)		
Stocks/Bonds/CDs and other owned property		

EXPENSES

Item	Total Amount Owed	Monthly Payments	Description
Home Mortgage			
Rent (Monthly Payment)			
Utilities (Elec,Water,etc.)			
Groceries and Childcare			
Medical Bills			
Alimony/Child Support			
Prescription Medicines			
Bank Loans (Personal, Student Loans, etc)			
Insurance (Auto, Health, etc)			
Credit Card Debt			
Other (Explain)			
Total Expenses (Lines 1-11)			

Consents for Release of Information/Certification Statement

Consent/Certification for Iowa

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 agreements previously made. I hereby grant permission to UnityPoint Health, its affiliates and representatives to investigate the information contained herein. Documentation must be provided.

I also agree to notify UnityPoint Health of any changes in my financial position that would impact this determination

Consent/Certification for Illinois

I certify that the information in this application is true and correct to the best of my knowledge. I will apply for any state, federal or local assistance for which I may be eligible to help pay for this hospital bill. I understand that the information provided may be verified by the hospital, and I authorize the hospital to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible fo the payment of the hospital bill.

Complaints or concerns with the uninsured patient discount application process or hospital financial assistance process may be reported to the Health Care Bureau of the Illinois Attorney General.

1-800-243-0618 https://illinoisattorneygeneral.gov/

Preparer's Signature _____ Date _____

Spouse's Signature _____ Date _____

Your complete application and all supporting documents* may be submitted via:

Mail:
UnityPoint Health Financial Assistance
PO Box 809330
Chicago, IL 60680-9330

*Do not mail original documents. Send copies only. Documents will be destroyed after being scanned.

Email: FA_CBO_Request@unitypoint.org
Fax: (515) 381-7166
Write: **"FA Application"** on fax cover sheet.

Questions? For FINA questions only call 833-874-4243 and for all billing questions call 844-849-1260