Financial Assistance Program – Plain Language Summary

Manning Regional Healthcare Center (MRHC) 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. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, MRHC strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. MRHC will provide, without discrimination, care of emergency medical conditions to individuals regardless of their eligibility for government assistance or their ability to pay.

Financial Assistance Available to Those Who Qualify

Manning Regional Healthcare Center has financial assistance available up to 300% of the Federal Poverty Income Guidelines for those who qualify. Patients need to complete an application and supply minimal financial information to establish eligibility. Patients eligible for financial assistance will not be charged more than the calculated amount generally billed (AGB) by our organization for medically necessary care.

In order to qualify for assistance, you must:

- ☐ Complete entire application form; Hospital has staff available to assist if necessary
- ☐ Copy of most recent filed tax return
- ☐ Provide documentation of all income sources listed on application
- ☐ Provide copies of last 3 month’s bank statements
- ☐ Provide evidence that you have pursued all other payment sources including public aid
- ☐ Provide other information as necessary based on individual financial situations
- ☐ Provide a copy of other substantial medical bills if applicable

Our financial assistance policy, application, and this plain language summary are available on our website at www.mrhcia.com, in person at Manning Regional Healthcare Center, or may be obtained free of charge via mail by calling 712-655-2072.

Please return the financial assistance application and all required attachments within 30 days to:

Manning Regional Healthcare Center
Attn: Patient Financial Services
1550 6th St.
Manning, IA 51455

If you have any questions or need assistance to complete the application, please contact our staff by calling 712-655-2072 or stop by Manning Regional Healthcare Center.

Manning Regional Healthcare Center
Financial Assistance Program Application

Patient Information

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

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

Patient Address: ______________________________ (Street)

Home Phone: ____________________

US Citizen? ☐ Yes ☐ No

______________________________ (City) (State) (Zip Code)

Cell Phone: ____________________

Email Address: ______________________________

Work Phone: ____________________

Responsible Party Information (Guarantor)

Personal

Name: ______________________________ (Last) (First) (Middle)

Address: ______________________________ (Street)

______________________________ (City) (State) (Zip Code)

Home Phone: ________________ Cell Phone: ________________

Email Address: ______________________________

Date of Birth: ________________ SSN: __ __ __-__ __-__ __ __ __

Employment

Employer: ______________________________

Address: ______________________________ (Street)

______________________________ (City) (State) (Zip Code)

Work Phone: ______________________________

Spouse Employer: ______________________________

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

☐ Federal Tax Return (most recent) ☐ 3 Mo. Bank Statements ☐ Public Aid Denials

☐ Current Pay Stub(s) (Responsible Party, Spouse & **ALL** Other Family Members over the age of 18)

Optional: ☐ A copy of a photo ID of the responsible party

Other Income Source Documentation:

☐ Social Security ☐ VA Assistance ☐ Railroad Retirement ☐ Child Support

☐ Disability ☐ Life Insurance ☐ Pension/Annuity ☐ Alimony

☐ Unemployment ☐ Workman's Comp ☐ Public Assistance ☐ Rental Property Income

☐ Other (please list) ______________________________

ASSETS

Cash on Hand $____________ Stocks/bonds/retirement $____________ Vehicles $____________

Savings Accounts $____________ CD's (Total Value): $____________ Vehicles $____________

HSA/HRA Acct Values $____________ FLEX Account Values $____________ Vehicles $____________

Recreational Vehicles (RV's, Boats, ATV, Cycles): Description: ____________________ Value $____________

List All Other Person(s) Besides Responsible Party Living in the Households

Name	Relationship	Birth Date	Insurance Coverage for Dependent

Attach a schedule 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 by result in the immediate cancellation of any agreement previously made. I hereby grant permission to Manning Regional Healthcare Center, its affiliates and representatives to investigate the information contained herein. By providing my wireless/cell phone number, I hereby grant Hospital and its agents my consent to use to contact me for billing, debt collection purposes and financial assistance program. I also agree to notify [Hospital] of any changes in my financial position that would impact this determination.

______________________________ (Responsible Party Signature)

____________ (Date)