MANNING REGIONAL HEALTHCARE CENTER
An Affiliate of MERCYONE
CLINIC • HOSPITAL • RECOVERY CENTER

1550 6th Street
Manning, Iowa 51455
(712) 655-2072
www.mrhcia.com

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 essential services to individuals regardless of their eligibility for government assistance, their ability to pay, or based upon the individual's race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity.

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
- □ Provide copy of most recent filed tax return or other proof of income
- □ Provide documentation of all income sources listed on application
- □ 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)
_____ (City) _____ (State) _____ (Zip Code)
Home Phone: _____
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: _____

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)
☐ 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

Adequate information must be made available to determine eligibility for the program. If above documents are not provided, MRHC may seek other means from patient to determine eligibility.

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) _____

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)