1000 Lincoln Circle SE
Orange City, IA 51041

Dear Patient,

Attached is the packet of information you need to complete to be considered for financial assistance at the Orange City Area Health System. Please return completed disclosure statement. You may include any additional information you feel would be helpful to us. The financial assistance program does not cover elective services.

PROOF OF INCOME IS REQUIRED

The following information is required to consider your application:

□ Have you checked with Department of Human Services to see if you qualify for medical assistance? ____ yes ____ no If yes, did you qualify? ____yes ____no

□ 3 months of bank statements prior to the date of application.

□ A copy of your most recent Federal tax return.

*If any questions regarding this application please contact:

Judy De Jong - 737-5334

Steve Walhof - 737-5267

Orange City Area
Health System

Summary of Financial Assistance Policy

Orange City Area Health System has an extensive Financial Assistance Policy. We offer financial assistance for emergency and medically necessary services. This assistance, ranging from a reduction in the amount of the balance outstanding up to complete forgiveness of the balance outstanding, is provided to patients demonstrating financial need.

The assistance is provided on a sliding scale discount based upon verifiable total household income as a percentage of the federal poverty level (FPL) guideline. Please reference the following table:

Annual Family Income	Minimum Discount
225% or less of FPL	100%
226% - 275%	75%
276% - 325%	50%
326 – 375%	25%
376% or above of FPL	0%

Exceptional financial circumstances: If your total household income exceeds the maximum 375 percent of the FPL, yet you have supplied additional documentation to support the hardship your medical condition has caused for you and your family, you will be considered on a case by case basis for assistance.

Notification of availability of our Policy: Every effort will be made to identify patients needing assistance as early as possible. Orange City Area Health System will widely publicize the program through (1) signs at registration areas in our hospitals and clinics, (2) policy, summary, and application available at the Orange City Area Health System website, (3) patient billing statements, (4) informational materials provided to the patient and family, and (5) healthcare providers and staff identifying patients with potential financial need.

Services covered by a financial assistance application: An approved Financial Assistance application will cover charges for emergency and medically necessary care provided.

Extraordinary collection activities: Orange City Area Health System will not engage in extraordinary collection activities, such as lawsuits or garnishments, before making reasonable efforts to determine whether an individual who has an unpaid account is eligible for financial assistance.

How to obtain an application or copy of our policy: You may obtain an application or a copy of our policy by visiting our website at https://www.ochealthsystem.org. If you do not have access to the internet, you may contact a patient account specialist at our Patient Financial Services offices at 712-737-5200 or 1-800-808-6264.

Orange City Area Health System
STATEMENT OF FINANCIAL CONDITION

Name ________________________ Spouse ________________________

Address ________________________ Occupation ________________________

City________________ State_________ Zip ___________Phone Number _________________

Full Name of Dependents and Age

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Please list all of the following information as it pertains to your financial status today. Please submit any verification of the information that may be available.

ASSETS

1. Accounts and Notes Receivable to You From Others $_________
2. Investments (Stocks, Bonds, Securities, etc.) $_________
3. Real Estate $_________
4. Automobile – Year/Type $_________
5. Other Personal Property $_________
6. Other Assets: Checking $_________
   Savings $_________

TOTAL ASSETS $_________

PLEASE ATTACH COPIES OF YOUR MOST RECENT/COMPLETED INCOME TAX RETURN TO SUPPORT THE FOLLOWING INFORMATION.

EARNINGS

1. Total Monthly Income (Please attach itemized schedule) $_________
2. Total Monthly Income for Spouse $_________
3. Other Monthly Income: Rental/Lease, Commissions, bonuses, dividends, etc. $_________
4. Monthly Unemployment (if applicable) $_________

TOTAL EARNINGS $_________

LIABILITIES

1. Amount of all OCAHS & OC Medical Clinic bills $_________
2. Amounts of other Medical Bills $_________
3. Notes Payable to Banks or Other Financial Institutions $_________
4. Notes Payable to others $_________
5. Mortgages on Real Estate $_________
6. Mortgages on Other Property $_________
7. Credit Card Bills $_________
8. Accounts and Bills Due $_________
9. Unpaid Income Tax and/or Interest $_________
10. All Other Current debts or liabilities (Please attach itemized schedule) $_________ $_________

TOTAL LIABILITIES _________

Do you own or rent your home? _________
Monthly Payment? $_________

FOR OFFICE USE ONLY
Approved _____________ Denied _____________
Comments_____________________________
____
____

BO 136
08/06/18

OTHER FINANCIAL INFORMATION

1. Marital Status (Single, Married, Widowed, Divorced) ____

2. Do you anticipate receiving any gifts, inheritances or money from land sales or any other source in the near future? ______ If yes, please explain ____
____
____

3. Please list all employers and dates of employment, for you (and spouse) during the last two years.
____
____

4. Have you ever declared bankruptcy? ____
If so, when? ____

5. Do you have any judgments or liens filed against you? ________ If so, please identify by creditor, amount, date of entry or judgment of lien and county where filed.
____
____

6. Have you ever received any welfare benefits from any governmental or third party source (county welfare payments, food stamps, Medicaid, Emergency Energy Assistance, etc.)?_____________________________
If you have received such benefits, please state the nature and type of relief received and the time period that you received such benefits____
____
____

The above information will be kept confidential and will only be used in the determination of full or partial forgiveness of a medical obligation to Orange City Area Health System. The undersigned certifies that both sides hereof and the information inserted therein has been carefully read and is true and correct best to the knowledge of the undersigned.

____ ____________________________
Signature Date

Please mail to: Orange City Area Health System
(Choose one)

Attn: Judy De Jong	or	Attn: Steve Walhof
1000 Lincoln Circle SE		1000 Lincoln Circle SE
Orange City, IA 51041		Orange City, IA 51041