Compass Memorial Healthcare-Business Office

300 West May Street
Marengo, Iowa 52301

Phone: 319-642-5543
Fax: 319-642-8142

Thank you for your interest in Compass Memorial Healthcare's Financial Assistance Program. Our Financial Assistance Program is designed to help you with your medical bills for services received at Compass Memorial Healthcare and Clinics. Enclosed, you will find the financial assistance application. Please keep the following in mind while completing the application:

- This is not a health insurance; it is financial assistance for your Compass Memorial Healthcare and Clinic bills only. Because it is not a health insurance plan, the Financial Assistant Program can only cover services that are billed directly through Compass Memorial Healthcare. This means that it can only assist with charges for Compass Memorial Healthcare facilities, and charges incurred with doctors employed by Compass Memorial Healthcare.

- Our Financial Assistance Program assists with your bills for medically necessary services, and does not assist with bills for prescription medications, retail services, or some elective services.

- When filling out the application, it is important that you provide us with current information, even if your situation has changed since you incurred your bills with Compass Memorial Healthcare. Financial Assistance eligibility is based on your current household income.

- To be eligible for Financial Assistance, you must complete the application within 240 days of your first billing statement for the services you are applying for. If an application is received after the 240 days of your first billing statement, it will be automatically denied, and you will be responsible for the payment of that service.

- Our current policy now requires all patients that are applying for Financial Assistance also apply for Iowa Medicaid. T**o qualify for Financial Assistance, you would need to be approved or denied for Iowa Medicaid.** A copy of the Medicaid denial letter would need to be submitted with the application. Some guidance on the next page on how to apply.

    - If you need assistance or have questions you can call the DHS Contact Center at 1-855-889-7985. Their hours of operation are Monday-Friday 8:00am – 5pm.

BELOW IS THE WEBSITE TO APPLY FOR IOWA MEDICAID

https://dhsservices.iowa.gov/apspssp/ssp.portal

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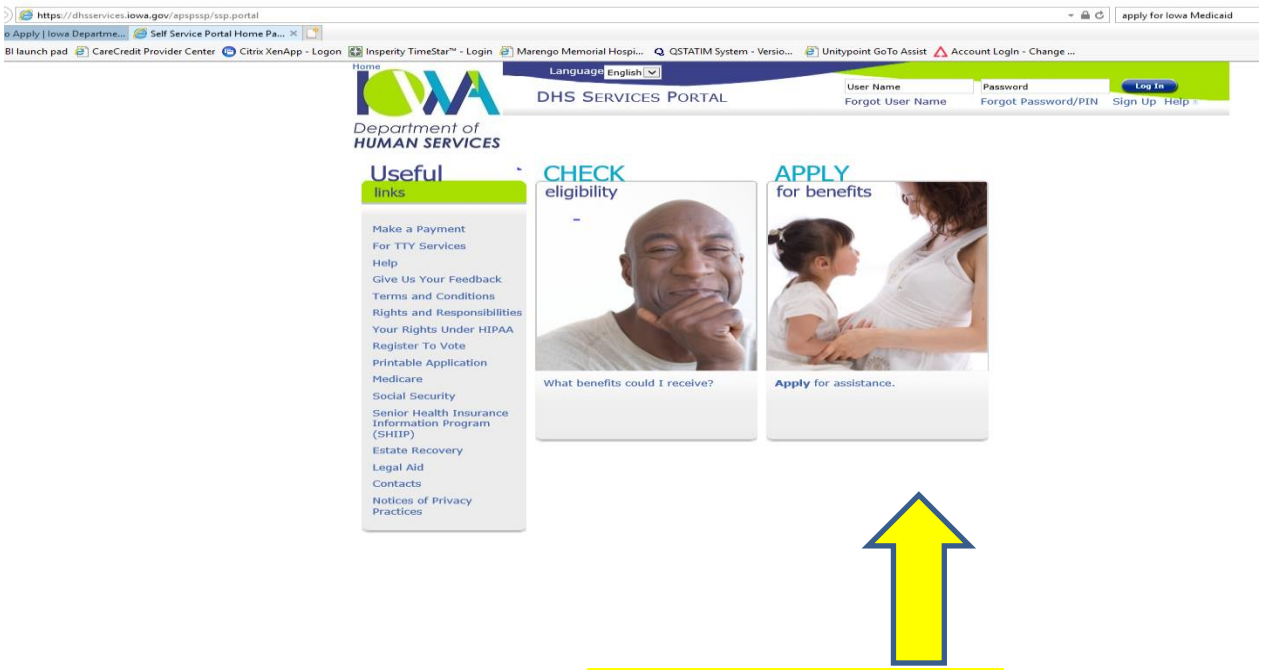
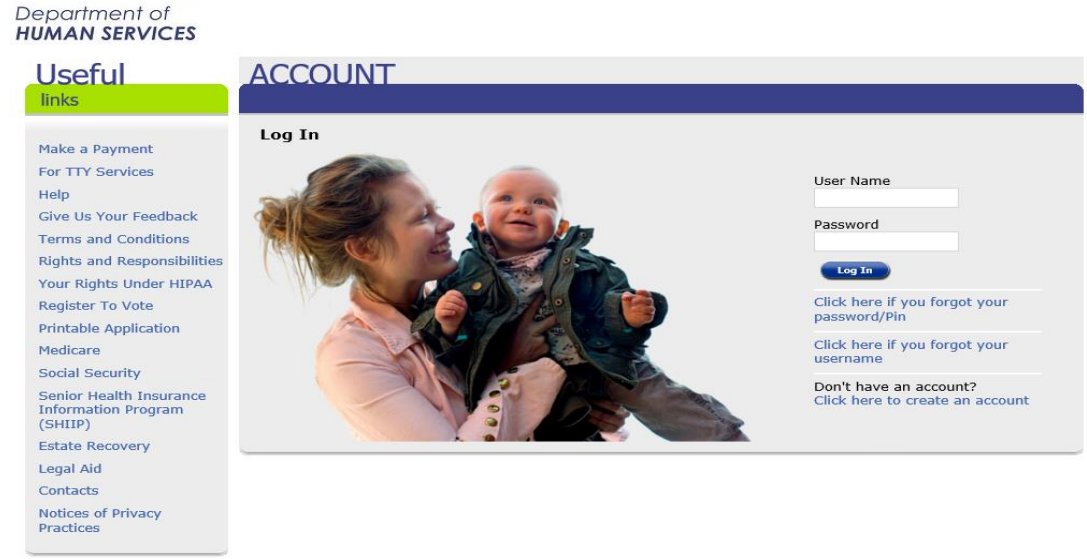


Select Apply for Assistance

You will need to set up a username and password to complete the form



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Application Checklist

1. Apply for Medicaid if you have not already done so.
   a. If you have applied for CMH financial assistance in the past 3 years and were denied Medicaid and have had no significant changes to your income, you may only need to complete the Pre-Screening Self-Assessment Tool.
   b. Complete and print the financial information and Results
   c. If the results say you will not be eligible for healthcare costs, then you do not need to apply for Medicaid. If the results say someone in your household maybe eligible for low or no cost healthcare insurance, then you must complete the Medicaid application.

2. Complete pages 1 and 2 of the application.

3. Be sure to get all applicable signatures (spouse if married).

4. If you have been approved for Medicaid submit the following:
   - ☐ Pages 1 and 2 of the application
   - ☐ Proof of Medicaid approval

5. If you have been denied Medicaid please submit the following:
   - ☐ Pages 1 and 2 of the application
   - ☐ Proof of Medicaid denial
   - ☐ Most recent tax returns if you do not have a tax return or your situation has changed, please also submit the following:
     Copy of last month checking and/or savings statements (if applicable)
     Copy of your Social security award letter (if applicable)
   - ☐
   - ☐ A copy of the unemployment benefits (if applicable).
   - ☐ A copy of your most recent certified Financial Statement (business owners/self-employed)
   - ☐ A copy of your last month's checking and savings statements (if applicable)

If you are unsure about what documentation to include with your application, or if you need any other assistance with this application, please contact us at 319-642-5543.

Sincerely,

The Compass Memorial Healthcare Business Office

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Compass Memorial Healthcare Financial Assistance Program Application

Patient Information

First Name:		**Last Name:**	**MI:**
Street Address:		**City:**	**State:**
Date of Birth:	**Social Security:**	**Home Phone:**	**Cell Phone:**
Is patient a minor? ❑ **Yes** ❑ **No**		**Hospital Account Number:**	
Marital Status: ❑ Single	❑Married	❑ Divorced	❑ Widowed

Person Responsible for Payment: Demographic Information

❑Check if patient is person responsible for payment (If checked, proceed to employment information section)

First Name:		**Last Name:**	**MI:**
Street Address:		**City:**	**State:**
Date of Birth:	**Social Security:**	**Home Phone:**	**Cell Phone:**
Marital Status: ❑Married	❑ Single	❑ Divorced	❑ Widowed

Person Responsible for Payment: Employment Information

❑Check if not employed

Employer Name:		
Street Address:	**City:**	**State:**
Phone Number:	**Monthly Gross Income:**	

Person Responsible for Payment: Spouse Demographic Information

❑Check if not applicable

First Name:		**Last Name:**	**MI:**
Street Address:		**City:**	**State:**
Date of Birth:	**Social Security:**	**Home Phone:**	**Cell Phone:**

Person Responsible for Payment: Spouse Employment Information

❑Check if spouse is not employed

Employer Name:		
Street Address:	**City:**	**State:**
Phone Number:	**Monthly Gross Income:**	

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Dependents: All Dependents Claimed on Federal Tax Return

❑Check if not applicable

Name:	**DOB:**	**Age:**
Name:	**DOB:**	**Age:**
Name:	**DOB:**	**Age:**
Name:	**DOB:**	**Age:**

All Other Income Sources

Source of Income_Amount Received_How Often Received	Name of Person Receiving		
Other Household Income			
Unemployment Income			
Social Security			
Child Support/Alimony			
Pension			
Interest/Dividend			
Other (explain)			

❑Check if you do not have additional income sources to report

I am/ We are herewith applying for assistance through Compass Memorial Healthcare and Clinics. I verify under penalties of law that everything contained within this application is true and correct to the best of my knowledge and that nothing contained in this application was falsified in order to receive assistance. I understand that I/We may not be approved financial assistance in which case, I/We must make a good faith effort to promptly pay the balance which may be owed to Compass Memorial Healthcare and Clinics. **I hereby authorize Compass Memorial Healthcare to verify any information contained in this application (either verbally or in writing), with of the references or creditors shown.**

Primary Applicant's Signature:	**Date:**
Spouse Signature:	**Date:**