

Application for Financial Assistance

Des Moines University Clinic is a nonprofit health organization with a commitment to assist those who seek our care, regardless of their ability to pay.

If you are unable to pay for all or part of the care you receive from our clinics, you may be eligible for free or discounted services.

You may qualify for 100% of your care provided for free, or a discounted charge under one or all of these criteria:

- Your family income is low. Free care may be available to patients with family earnings less than or equal to 200 percent of the Federal Poverty Income Guidelines (FPIG) for the current year who are uninsured or underinsured.
- Discounts may be provided for financially needy underinsured or uninsured patients earning between 201% and 400% of the FPIG household income for the current year.
- Patients may also be eligible for financial assistance based upon medical indigency. Des Moines University Clinic may determine a person is “medically indigent” if they are unable to pay some or all of their medical bills because those medical bills exceed a certain percentage of their family or household income and/or assets (for example, bills due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the eligibility requirements for free or discounted care.

Patients applying for financial assistance must exhaust all options available to them for insurance coverage including, but not limited to, applying for Medicaid coverage prior to receiving financial assistance.

HOW TO APPLY FOR FINANCIAL ASSISTANCE

When you are registered as a patient, we will ask about your coverage for health care services. If you don’t have coverage, or it is not likely to be sufficient, we will either give you a packet of information that covers our financial assistance policy or offer immediate assistance to review the policy and application with you.

If you participate in any of the following programs we will not need to see your tax information or pay stub, but will need proof that you are currently enrolled.

- Food Stamp Program
- Family Investment Program
- Mothers and Children Program (MAC)
- Iowa Family Planning Network
- Medically Needy Program
- County Relief Programs
- Mercy Medical Center — Des Moines Financial Assistance
- UnityPoint — Des Moines Financial Assistance

If you participate in one of the programs listed above, you will only need to complete the following sections of the application:

- Applicant Information
- Spouse/Applicant Information
- Other Information
- Certification and Release of Information

If you are not enrolled in any of the above programs, the following application must be completed and the required documents must be provided.

Eligibility will be determined using, but not limited to, the following:

- Household gross income
- Household net worth, including liquid and non-liquid assets
- Household employment status
- Household financial obligations
- Household existing and future need for services

The willingness and ability to disclose the above information will be considered when determining the need and extent of assistance. The amount of benefit for which a patient is eligible will be determined based on federal poverty guidelines and financial resources disclosed in this application.

DOCUMENTS REQUIRED FOR PROCESSING

Please provide documents for everyone in your household (if applicable).

- Des Moines University Clinic application for financial assistance
- Tax return (most recent year)
- Most recent pay stub, proof of monthly pension or social security award letter
- State unemployment claim and final pay statement from last job
- Monthly pension amount letter
- Disability income amount letter
- Social Security income amount letter
- Proof of income from child support/alimony

Once all information has been received, clinic administration will process the information based on the federal guidelines. A letter disclosing the amount of eligibility or the reason for denial will be sent to the applicant.

Eligibility can be applied up to one year and shall be in effect for one year from the date of service to which a financial assistance discount is applied.

Applicant Information

Personal			Employment		
Name			Employer		
Address			Address		
City	State	ZIP	City	State	ZIP
Phone			Phone		
Birthdate	Age		Job Title		
Social Security Number			Job Status	<input type="checkbox"/> PT <input type="checkbox"/> FT	Avg. Weekly Hours
Marital Status			Weekly \$		

Spouse/Applicant Information

Personal			Employment		
Name			Employer		
Address			Address		
City	State	ZIP	City	State	ZIP
Phone			Phone		
Birthdate	Age		Job Title		
Social Security Number			Job Status	<input type="checkbox"/> PT <input type="checkbox"/> FT	Avg. Weekly Hours
Marital Status			Weekly \$		

Other Information

All Other Person(s) Living in Household			Second Employer for Applicant or Spouse <i>(if applicable)</i>		
<i>Name</i>	<i>Relationship</i>	<i>Age</i>	Employer		
			Address		
			City	State	ZIP
			Phone		
			Job Title		
			Job Status	<input type="checkbox"/> PT <input type="checkbox"/> FT	Avg. Weekly Hours
			Weekly \$		

Other Sources of Income

Source of Income	Check One	Amount Received	How Often Received	Name of Recipient
Social Security	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Child Support/Alimony	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Pension	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Disability/Worker's Comp.	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Interest/Dividend	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Unemployment	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		
Other (explain):	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$		

Assets

<i>Item</i>	<i>Amount</i>	<i>Description</i>
Checking Account	\$	
Savings Account	\$	
Stocks/Bonds/CDs	\$	
Motor Vehicles	\$	
Primary Residence (Assessed Value)	\$	
Other Property	\$	
Total Assets (Lines 1-6)	\$	

Liabilities

<i>Item</i>	<i>Total Amount Owed</i>	<i>Monthly Payments</i>	<i>Description</i>
Home Mortgage	\$	\$	
Rent (Monthly Payment)	\$	\$	
Utilities (Electricity, Water, etc.)	\$	\$	
Medical Obligations	\$	\$	
Prescriptions	\$	\$	
Bank Loans (Auto)	\$	\$	
Loans (Personal, Education, etc.)	\$	\$	
Health Insurance	\$	\$	
Insurance (Auto, Home, etc.)	\$	\$	
Credit Card Debt	\$	\$	
Other (Alimony, Settlements, etc.)	\$	\$	
Total Liabilities (Lines 1-11)	\$	\$	

Other Comments or Special Circumstances

Certification and Release of Information

I certify that the information provided above is accurate and true. I also certify there is no additional insurance coverage for this family other than what has been presented to Des Moines University (DMU) Clinic. I understand providing false information will result in denial of this application or cancellation of any financial assistance benefits provided by DMU Clinic. If I receive any compensation/ payment from third party payers (including insurance companies) or if I am eligible for other assistance (including Medicaid), I will take any action necessary or requested by DMU Clinic to get such assistance and will transfer, and upon receipt will pay, DMU Clinic all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process and required documentation will result in cancellation and denial of this application. Each of the undersigned hereby acknowledges that DMU Clinic may verify or re-verify any information contained in this application through any source, including a source named in this application or a consumer reporting agency.

I also agree to notify Des Moines University Clinic of any changes in my financial position that would impact this determination.

Preparer's Signature	Date
Spouse's Signature	Date

*Return completed form to: Des Moines University Clinic, 3200 Grand Avenue, Des Moines, Iowa 50312-4198.
Need assistance? Call 515-271-1700 and select option #7.*