

**MANNING REGIONAL HEALTHCARE CENTER  
PATIENT FINANCIAL ASSISTANCE INFORMATION SHEET**

Please complete the following application within 30 days and return it along with the required attachments to Manning Regional Healthcare Center, 410 Main Street, Manning, Iowa 51455. Hospital Administration will determine if requests meet eligibility criteria and a written notice will be sent to the applicant with the results of their decision.

Financial assistance may be applied to services received at Manning Regional Healthcare Center up to 12 months prior to receipt of the Patient Financial Assistance application but will not apply to future services received at Manning Regional Healthcare Center unless a new application is filed at that time.

All information provided on the application or within the attachments will be held in the strictest confidence.

**Eligibility Criteria:**

**Insurance Coverage:**

A patient seeking Patient Financial Assistance must first apply for State Assistance through the Department of Human Services Medicaid Program to determine if they qualify for medical insurance benefits.

**Income:**

Income is based on family income. Eligibility for and the amount of benefit, if any, are determined based on a sliding income scale. This scale is a function of the Federal Poverty Guidelines and, as such, will change as those guidelines are adjusted.

**Department of Health & Human Services – Income Poverty Guidelines**

Effective: January 16, 2009 – March 31, 2010

<b>Size of Family Unit</b>	<b>Poverty Guideline</b>
1	\$10,830
2	\$14,570
3	\$18,310
4	\$22,050
5	\$25,790
6	\$29,530
7	\$33,270
8	\$37,010

For family units with more than 8 members, add \$3,740 for each additional member.

An applicant may be eligible if his or her income for the 12 months preceding the eligibility determination or the previous three months income annualized meets the following scale:

**Manning Regional Healthcare Center Write-Off Percentages**

<b>Percent of Poverty Guidelines</b>	<b>Discount from Gross Charges</b>
At or Below Poverty	100%
101% - 110%	90%
111% - 120%	80%
121% - 130%	70%
131% - 140%	60%
141% - 150%	50%
151% - 160%	40%
161% - 170%	30%
171% - 180%	20%
181% - 190%	10%
191% and up	0%

Income, for purposes of this policy, refers to all cash receipts before taxes from all sources. It includes wages and salaries before any deductions. It includes receipts from self-employment or business or farm after business expenses, excluding depreciation. It includes payments from public assistance, social security, unemployment and worker’s compensation, veteran’s benefits, alimony, child support, military family allotments, government and private pensions, insurance and annuity payments, income from dividends, interest, rents, royalties, estates and trusts, college and university scholarships, grants, fellowships and assistantships, gambling and lottery winnings. In addition, income includes resources drawn down from bank accounts, the sale of property, tax refunds, gifts, loans, inheritances, insurance lump payments, and compensation for injury. The above-identified sources of income are not an exhaustive list, and are provided only as examples of income.

If an adult member of a household is unemployed, a copy of the person’s filing with Iowa Workforce Development Unemployment Office is required.

**Assets:**

Assets also affect the amount of benefit that may be awarded. It is not the desire or intent of this policy to force people to sell assets or to incur additional debt. However, the hospital and its Board of Directors have certain fiduciary duties that require that financial assistance benefits only be granted to those patients truly in need. Therefore, the following asset limits also apply:

- Individual: Liquid assets cannot exceed \$1,000.00
- Family: Liquid assets cannot exceed \$2,000.00

Non-liquid assets (real estate, long-term investments, recreational vehicles, boats, etc.) will also be considered, and a statement of the fair market value for such assets must be provided.

The total amount of financial assistance provided by the hospital during the fiscal year will be determined on a first-come, first-serve basis, until the amount budgeted has been exhausted. The hospital will make a determination whether or not to continue taking applications for Patient Financial Assistance at the time the budgeted amount for such assistance has been expended.

**REQUIRED ATTACHMENTS TO**  
**PATIENT FINANCIAL ASSISTANCE APPLICATION**

- \_\_\_\_\_ Denial letter from Department of Human Services Medicaid Program if not already receiving Title XIX benefits.
- \_\_\_\_\_ Last 3 months' pay stubs
- \_\_\_\_\_ Last 3 months' bank statements (checking, savings, personal, and/or business)
- \_\_\_\_\_ Most recent tax return
- \_\_\_\_\_ Current financial statement (listing of assets and liabilities)
- \_\_\_\_\_ Documentation of other income (i.e., unemployment, dividends, pension, retirement, public assistance, social security, worker's compensation, child support, alimony, rental income, etc.)

Applications missing any of the items listed above will not be processed.

If a situation exists that you are unable to provide one or more of the items listed above, please include an explanation to that effect.

Payment will be expected if a complete application, including the items listed above, is not returned within 30 days.



Homeowners: Equity in Home: \_\_\_\_\_

Renters: Name & Address of Landlord: \_\_\_\_\_

Savings:

Amount: \_\_\_\_\_ Name of Institution: \_\_\_\_\_

Checking:

Amount: \_\_\_\_\_ Name of Institution: \_\_\_\_\_

CD's: \_\_\_\_\_ Name of Institution: \_\_\_\_\_

Stocks/Bonds: \_\_\_\_\_

Motor Vehicles:

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Make	Year	Monthly Payment
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Make	Year	Monthly Payment
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Make	Year	Monthly Payment
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Real Estate:

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Type	Net Fair Market Value
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Personal Property:

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Year & Type (Boat, ATV, Motorcycle, Etc.)

I certify that the answers given by me to the foregoing questions and statements are true and correct without consequential omissions of any kind whatsoever.

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Signature of Applicant	Date
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Signature of Spouse	Date
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