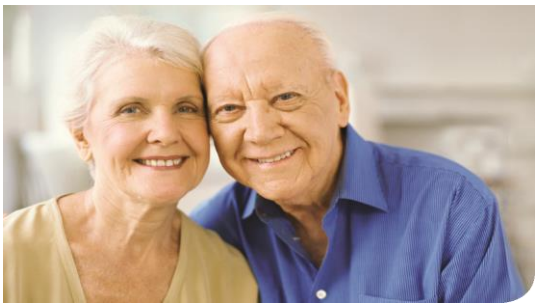
Financial Assistance

Loring Hospital

Your Family Health Center

An Affiliate of UnityPoint Health

"Best outcome for every patient every time."



Loring Hospital knows there are times when our patients cannot pay for the services provided. If you need help paying for medical services, you may be eligible for financial assistance from Loring Hospital.

To see if you qualify, please follow the instructions below.

If you already receive help from a state program (like Food Stamps or WIC), just fill out page one of the application and send it in with proof that you are in one of these programs. You may qualify for automatic participation in our program. Be sure to sign the last page of the application.

Be sure to give full information for everyone living in your home, and complete the three sections on the right side of the form. If you don't return complete information your request can not be processed. All information will be kept private.

We can help with this form if you have questions.

- **If you are in the hospital, ask for someone in the Business Office.**
- **If you are at home, call 800-344-3767.**

IMPORTANT NOTES

Our team members may try to find out if you qualify for other federal or state assistance programs prior to processing your request for Financial Assistance from Loring Hospital.

Financial assistance is only available for medically necessary services provided by Loring Hospital, as outlined in the Financial Assistance Policy. If you would like to learn more about this policy visit **loringhospital.org/fap.**

If you have more questions about your bill, please call the phone number listed on the bill or Loring Hospital, 800-344-3767.

COMPLETE ALL 3 SECTIONS

1. Financial Assistance Application

Fill this attached form out completely, please remember to sign the bottom of page two.

You only need to fill out one form for everyone living in your home.

2. Proof of Income for everyone in your home:

Send copies of all items listed below that apply.

- ☐ Tax return for last year
- ☐ If you are employed: a pay stub with year-to date income OR your last 3 pay stubs
- ☐ If you are self-employed: balance sheet and income statement
- ☐ If you are unemployed: state unemployment claim AND final pay stub from last job
- ☐ Monthly pension amount letter
- ☐ Disability income amount letter
- ☐ Social security income amount letter
- ☐ Proof of income from rent
- ☐ Proof of income from child support
- ☐ Proof of income from alimony
- ☐ If you have NO income, written statement from the person who supports you

3. Proof of Assets for everyone in your home:

- ☐ Bank statements from the last 3 months
- ☐ Investment statements (401K, IRA, investment account, health savings account)

Loring Hospital
Your Family Health Center
An Affiliate of UnityPoint Health

Financial Assistance Application

REASON YOU NEED ASSISTANCE WITH YOUR BILL:

_____

_____

PATIENT NAME:

Name _____
(Last) (First) (MI)
Address _____
(Street)
_____
(City) (State) (Zip)

Telephone _____

Birthday _____ Age _____

Soc.Sec.No. _____ Marital Status _____

PERSON RESPONSIBLE FOR PAYMENT:

Name _____
(Last) (First) (MI)
Address _____
(Street)
_____
(City) (State) (Zip)

Telephone _____

Birthday _____ Age _____

Soc.Sec.No. _____ Marital Status _____

Employer _____

Address _____
(Street)
_____
(City) (State) (Zip)

Telephone _____

Job Title _____

Job Status: PT FT Avg weekly hrs _____

SPOUSE OF PERSON RESPONSIBLE FOR PAYMENT:

Name _____
(Last) (First) (MI)

Address _____
(Street)
_____
(City) (State) (Zip)

Telephone _____

Birthday _____ Age _____

Soc.Sec.No. _____ Marital Status _____

Employer _____

Address _____
(Street)
_____
(City) (State) (Zip)

Telephone _____

Job Title _____

Job Status: PT FT Avg weekly hrs _____

OTHER INFORMATION:

List All Other People Living in the Household

Name Relationship Soc. Sec. No. Birthdate

_____

_____

_____

_____

_____

2nd Employer for Responsible Party and/or Spouse

Employer _____

Address _____
(Street)
_____
(City) (State) (Zip)
Telephone _____

Job Title _____

Job Status: PT FT Avg weekly hrs _____

Income			
Source of Income	Amount Received	How Often Received	Name of Person Receiving
Employment Income			
Employment Income			
Social Security			
Child Support/Alimony			
Pension/Comp/Unemployment			
Interest/Dividend			
Other (Explain)			

Assets		
Item	Acct Balance	Description
Checking Account		
Savings Account		
Stocks/Bonds/CD's		
401(K)/IRA/Health Savings Account		
Motor Vehicles (Make & Model / Year)		
Main Home (assessed value)		
Other Property Owned		
Total Assets (Lines 1-7)		

Expenses			
Item	Total Amount Owed	Monthly Payments	Description
Home Mortgage/Rent			
Utilities (Elec,Water,etc.)			
Medical Bills			
Alimony/Child Support			
Prescription Medicines			
Bank Loans (Car)			
Bank Loans (Personal, Student Loans, etc)			
Insurance (Auto, Health, etc)			
Credit Card Debt			
Other (Explain)			
Total Liabilities (Lines 1-10)			

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 may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Loring Hospital, its affiliates and representatives to investigate the information contained herein. I also agree to notify Loring Hospital of any changes in my financial position that would impact this determination.

_____

Preparer's Signature Date

_____

Spouse's Signature Date

Your Complete Application and all supporting documents may be submitted to:

(DO NOT send original documents, send copies.)

Loring Hospital
Attention: Business Office
211 Highland Avenue
Sac City, Iowa 50583

Write "FA Application" on fax cover sheet
fax: 712-662-6438
or email to: jwiseman@loringhosp.org