VIRGINIA GAY HOSPITAL
Clinics, Home Health, Nursing & Rehab

502 N 9th Ave • Vinton, IA 52349 Phone (319) 472-6200 www.myvgh.org

Application for Financial Assistance

1. A completed application must be returned to the Hospital/Clinic within 30 days of the date of issue.
2. Applicants will be eligible for financial assistance only on account balances which exceed the approved minimum deductible of their insurance company.
3. To be eligible for financial assistance, each applicant must first meet the minimum gross requirements established by the Federal Poverty Guidelines. If applicant meets gross income eligibility they may receive financial assistance.
4. The Hospital/Clinic reserves the right to request verification of income, via financial statements, tax returns, bank statements, and other documentation. Refusal of an applicant to provide the requested information will result in denial of financial assistance.
5. The Hospital/Clinic will submit a response to the applicant within 30 days of receipt of completed application.
6. Only one financial assistance determination will be made per account.
7. Financial assistance will not be granted in any of the following circumstances:
    a. Fraudulent information at the time of registration or on the application for assistance.
    b. Hospital stays or clinic visits not meeting Medical Necessity guidelines.
    c. Differences between Private room rate and Semi-Private room rate.
    d. Any portion of an account balance that is expected to be paid by a third party.
8. Financial assistance recipients will be responsible for paying minimum deductible and undiscounted balances in accordance with Hospital/Clinic payment policies and/or agreement. Failure to do so subject's any remaining balance to be turned over for collection procedures.

THE FOLLOWING ITEMS MUST BE SUBMITTED WITH YOUR APPLICATION, FAILURE TO PROVIDE THIS INFORMATION WILL RESULT IN DENIAL OF YOUR APPLICATION.

1. If you are uninsured, we'll need a copy of your denial from Medicaid.
2. Copy of your most recent paycheck stub/voucher.
3. Copy of Job Service of Iowa Income/Unemployment report for the last four quarters.
4. Copy of your most recent calendar year Federal Tax Return and W-2 Forms.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL 319-472-6300

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NAME APPLICANT INFORMATION:

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First Name Middle Name Last Name

ADDRESS: .....
Number & Street City State Zip

PHONE NUMBER: (.....) .....

How long have you lived at this address: .....Years ..... Months

Patient Name: .....Date of Service: .....

Type of Service:.....

FAMILY SIZE Number of Adults: ..... Number of Children: ..... Total:.....

EMPLOYMENT INFORMATION:

First Name	Employer	Employment Date	Hourly Pay	Hours Scheduled to Work

OTHER INCOME SOURCE: If none, please check here ☐

Category	When Paid	Monthly Income
Commissions		
Self Employment/Business Income		
Gross Farm Income (Sale of livestock, etc.)		
Workers Compensation		
Social Security		
Social Security Disability Income (SSI)		
Child Support/Alimony		
Veterans Benefits		
Railroad Retirement Benefits		
Disability Insurance Payment		
Income from Stocks, Bonds, Annuities, Investments		
Public or General Assistance		
Interest Income		
Retirement Income		

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I understand that the information submitted concerning annual income and family size is subject to verification. I also understand that information submitted on this financial assistance application which is false or misleading will result in a denial of the request.

Signature of Applicant: ..... Date: .....

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FOR HOSPITAL USE ONLY:

Date application was issued: ..... Date Returned: .....

Virginia Gay Hospital, Clinics, Home Health and Nursing Rehab does not and shall not discriminate on the basis of race, color, religion (creed), gender, gender expression, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its activities or operations.