Financial Assistance Program

Our Mission

The mission of Iredell Health System is to support our community's journey toward optimal health, to provide an excellent experience for our patients and their families, and to deliver high quality, afforable health services.

Community Commitment

For over 60 years, Iredell Health System, the only non-profit hospital in the County, has been proud to offer the highest quality health care to everyone regardless of their economic means. Iredell Health System carefully considers each patient's ability to pay for their medical care. We are committed to treating patients who have financial needs with the same dignity and consideration that is extended to all of our patients.

Iredell Health System offers a generous financial assistance program for patients. The program offers discounted charges to those who are uninsured, underinsured or simply cannot otherwise pay for all to their medical care.

The Financial Assistance Program supports medically necessary services to qualified patients on a "first-come-first-serve" basis until the annual budget has been reached. Iredell Health System's annual budget for free and discounted services is $13.1 million.

Eligibility*

Eligible patients who reside in a family or household where their net worth is less than $75,000 and their household or family income is within the ranges detailed below:

Discounts for Annual Income Less Than the Amount Below:

Family Size	100%	80%	60%	35%
1	31,598	36,022	40,445	44,869
2	38,775	48,469	58,163	67,856
3	43,973	54,929	65,915	76,900
4	47,336	59,170	71,004	82,838
5	55,416	69,270	83,124	96,978
6	63,496	79,370	95,244	111,118

Continued

Financial Assistance Program Continued

For family units with more than six members, the annual incomes above will be increased based upon federal guidelines.

Applying
If you think you may be eligible for the Program, we encourage you to **contact the Business Office at 704-878-4600.** An application and financial information will be required to determine eligiblity. You will be notified within one business day of the receipt of your completed application for medical services, not yet provided, and within two weeks for medical services previously provided.

Any financial assistance provided under this Program is conditional upon your applying for any government assistance for which you may qualify (i.e. Medicaid, Vocational Rehabilitation, etc.) If you need help completing an application for the above programs, we are more than happy to help.

Patients who do not provide the requested information necessary to completely and accurately assess their financial situation and/or who do not cooperate with efforts to secure governmental health care coverage will not be eligible for Iredell Health System's Financial Assistance.

Communication
If you are having trouble paying for all or some of your health care, we encourage you to talk with a financial couselor or someone in our business office about how we may be able to help you. Communication between the patient and the financial couselor is important. If you don't apply for discounts through the financial assistance program, you won't know if you qualify.

No Communication
If patients are unwilling to provide information for financial assistance or set up payment plans as appropriate, we cannot help. In these instances and when patients don't continue with their payment plan as agreed upon, the Hospital may ultimately be forced to turn unpaid bills over to a collection agency or take legal action. Having your bill turned over to a collection agency and/or a legal action will affect your credit status.

*Please understand that physician fees such as (anesthesiologist, emergency medicine, hospitalist, pathologist, radiologist, surgeon, etc.) are separate from hospital charges and may not be eligible for discounts.

Application for Financial Assistance Program Form

Patient Name _____ DOB_____

Please submit the following for all members of household:

The program requires that the applicant apply for Medicaid; please provide a copy of your decision letter; along with all of the following applicable items with your Financial Assistance application.

1) **W-2 Withholding or 1099 forms for the prior year and or a copy of the last year to date pay stub**
2) **Most recent year to date pay stub for the current year.**
3) **Statement of Social Security and or Retirement/Pension of monthly benefits or bank statement showing deposit for the prior and current year**
4) **Statement of Unemployment income with date benefits started and weekly amount**
5) **Income Tax Returns – most recent year filed**
6) **Bank- Detail checking account statement – most recent**
7) **Bank – Detail savings account statement – most recent**
8) **If no income, please include a letter of support; signed and dated, from the person who is providing for your daily living expenses.**
9. **If self- employed, please provide a statement of earnings for the prior year and the current year minus expenses, plus an inventory and value of equipment used for your business.**

If you are seeking financial Assistance for services not yet rendered, please provide the following:

Type of Service_____
Expected Date of Service _____
Ordering Physician/ Facility _____

Attention: Please keep in mind that failure to provide this information may delay or prevent your application from being approved.

Thank you!

P. O. Box 6029
Statesville, NC 28687-6029
704-873-5661

APPLICATION FOR FINANCIAL ASSISTANCE PROGRAM

Patient Name_____ DOB_____ Account #_____
Responsible Party_____ Social Security #_____
Address_____ City, State, Zip _____
How long at Address_____ Home: Rent_____ Own_____ Phone_____
Family # in household_____ - age's ____, _____, _____, _____, _____, _____
Employer_____ Address_____

Please provide the following for all members of the household

INCOME PER MONTH

Patient Gross _____
Responsible Party Gross _____
Spouse Gross _____
Rental Property _____
Child Support _____
Alimony _____
VA _____
Social Security _____
Retirement _____
Dividend/Interest _____
Unemployment _____
Other Household Income _____

TOTAL_____

EXPENSES PER MONTH

Loans _____
House Pmt/Rent _____
Food _____
Car Note(s) _____
Gas (Home use)_____
Electric _____
Water _____
Phone _____
Cable _____
Credit Card(s) _____
Child Care _____
School Tuition _____
Ins/Medical _____
Judgments/Fines _____
Child Support _____
Alimony _____
Other _____

TOTAL _____

AVAIL. CASH PER MONTH_____

BANKING
Checking YES ____ NO _____
Saving YES ____ NO _____

NAME OF BANK
_____
_____

I understand the information submitted is subject to verification by this facility, and may include checking my credit report. By signing, I am certifying the above information is true and accurate.

Applicant _____ Date_____
Spouse _____ Date_____
Witness _____ Date_____

APPLICATION FOR FINANANCIAL ASSISTANCE PROGRAM, CONTINUED

Patient Name _____DOB_____

List all assets and liabilities (attach separate sheet if necessary) for all members of the household

ASSETS (Description / Titled or in Name of)	VALUE
Cash on Hand, Checking Accounts, and Saving Accounts	$
Credit Union Savings, Mutual Funds, and Other Type Accounts	$
Stocks, Bonds and Retirement Accounts (Inc. IRA, 401K, etc.)	$
Car and Trucks (Make and Model **Own or Buying**	$
Other Transportation (Inc. Boats and Recreation Vehicles) **Own or Buying**	$
Home and Other Real Estate (Inc. Rental and Investment Property) **Own or Buying**	$
Furniture and Other Personal Property **(MUST GIVE VALUE)**	$
Cash Value of Life Insurance **(Amount you can cash in now)**	$
Other	$
TOTAL ASSETS	$

LIABILITIES (Company & Location)	AMOUNT OWED
Note: Only the total amount remaining on your loan/debt balance should be entered on the lines below	
Home Mortgage	$
Mortgage on Other Property	$
Loans on Vehicles	$
Credit Card (s)	$
Other Loans	$
Other Debt	$
TOTAL LIABILITIES	$

NET WORTH (assets minus liabilities) $

Note: If self-employed, give value of all equipment, supplies and inventory