Financial Assistance

UnityPoint Health
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 Patient Registration.
- If you are at home or the clinic, call (888) 343-4165

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 UnityPoint Health.

Financial assistance is only available for medically necessary services provided by UnityPoint Health organizations and physicians, as outlined in the Financial Assistance Policy. If you would like to learn more about this policy visit unitypoint.org/fap.

If you have more questions about your bill, please call the phone number listed on the bill to talk to the hospital, clinic, or home care that provided the care.

UnityPoint Health® 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 UnityPoint Health.

Complete All Three 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:
   Send copies of all items listed below that apply.
   - Bank statements from the last 3 months
   - Investment statements (401K, IRA, investment account, health savings account)
You may experience a delay in the processing of your application if all information is not provided.

☐ Proof of ALL income in household for those over 21 years of age
☐ 3 months of bank statements, checking/savings, ALL pages
☐ Last year’s 1040 tax return with ALL schedules

**PATIENT NAME**

Name __________________________ Telephone __________________________
(Last) (First) (MI)
Address __________________________ Birthday __________________________ Age ________
(Street) (City) (State) (Zip)
(Soc.Sec.No. __________ Marital Status ________

**PERSON RESPONSIBLE FOR PAYMENT**

**Personal Employment**

Name __________________________ Employer __________________________
(Last) (First) (MI)
Address __________________________ Address __________________________
(Street) (Street)
(Phone) (City) (State) (Zip)
(Phone) (City) (State) (Zip)
Birthday __________________________ Age ________
Job Title __________________________
Soc.Sec.No. __________ Marital Status ________
Job Status: ☐ PT ☐ FT Avg weekly hrs ________

**SPOUSE OF PERSON RESPONSIBLE FOR PAYMENT**

**Personal Employment**

Name __________________________ Employer __________________________
(Last) (First) (MI)
Address __________________________ Address __________________________
(Street) (Street)
(Phone) (City) (State) (Zip)
(Phone) (City) (State) (Zip)
Birthday __________________________ Age ________
Job Title __________________________
Soc.Sec.No. __________ Marital Status ________
Job Status: ☐ PT ☐ FT Avg weekly hrs ________

**OTHER INFORMATION**

List All Other People Living in the Household

Name __________________________ Relationship __________________________ Soc. Sec. No. __________ Birthdate ________

Second Employer for Responsible Party and/or Spouse

Employer __________________________
Address __________________________
(Street)
(City) (State) (Zip)
(Phone) __________________________
Job Title __________________________
Job Status: ☐ PT ☐ FT Avg weekly hrs ________

*All columns must be completed.*
## INCOME

<table>
<thead>
<tr>
<th>Source of Income (must provide documentation)</th>
<th>Amount Received</th>
<th>How Often Received</th>
<th>Name of Person Receiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employment Income</td>
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<td></td>
<td></td>
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<tr>
<td>Social Security</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Child Support/Alimony</td>
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<tr>
<td>Pension/Comp/Unemployment</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Interest/Dividend</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## ASSETS

<table>
<thead>
<tr>
<th>Item</th>
<th>Acct Balance</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking Account - provide 3 mos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Savings Account - provide 3 mos</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks/Bonds/CD’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>401(K)/IRA/Health Savings Account</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main Home (assessed value)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Property Owned</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Assets (Lines 1-7)**

## EXPENSES

<table>
<thead>
<tr>
<th>Item</th>
<th>Total Amount Owed</th>
<th>Monthly Payments</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Mortgage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent (Monthly Payment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilities (Elec, Water, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Bills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alimony/Child Support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription Medicines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bank Loans (Personal, Student Loans, etc)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurance (Auto, Health, etc)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Credit Card Debt</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Explain)</td>
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<td></td>
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</tr>
</tbody>
</table>

**Total Liabilities (Lines 1-11)**

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**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 UnityPoint Health, its affiliates and representatives to investigate the information contained herein. **Documentation must be provided.**

I also agree to notify UnityPoint Health 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 via:

**Mail:**
UnityPoint Health - Central Billing Office  
Attn: FA Team  
6200 Thornton, Suite 100  
Des Moines, IA 50321

**Email:**
FA_CBO_Request@unitypoint.org

**Fax:** (515) 362-5055  
Write: “FA Application” on fax cover sheet.

*Do not mail original documents. Send copies only. Documents will be destroyed after being scanned.