



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, affordable 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 eligibility. 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 counselor or someone in our business office about how we may be able to help you. Communication between the patient and the financial counselor 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 the household:

- 1) **Medicaid denial letter (patient only)**

And all of the following applicable items with your Financial Assistance application:

- 1) **W-2 Withholding Forms for prior year and or copy of last check stub.**
- 2) **Most recent check stub for the current year**
- 3) **Statement of Social Security and or monthly Retirement benefits; for the prior year and current year or bank statements showing deposit for the prior and current year**
- 4) **Unemployment Income Form**
- 5) **Income Tax Returns/ W2 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 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 _____

INCOME PER MONTH

EXPENSES PER MONTH

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

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

TOTAL _____

TOTAL _____

AVAIL. CASH PER MONTH _____

BANKING

NAME OF BANK

Checking YES _____ NO _____
 Saving YES _____ NO _____

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 _____
 Spouse _____
 Witness _____

Date _____
 Date _____
 Date _____

**APPLICATION FOR FINANANCIAL ASSISTANCE PROGRAM,
CONTINUED**

List all assets and liabilities (attach separate sheet if necessary)

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
<i>Note: Only the total amount remaining on your loan/debt balance should be entered on the lines below</i>	
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