DES MOINES UNIVERSITY CLINIC

# FINANCIAL ASSISTANCE PRESUMPTIVE ELIGIBILITY APPLICATION

Des Moines University Clinic is a nonprofit health organization with a commitment to assist those who seek our care, regardless of their ability to pay.

If you are unable to pay for all or part of the care you receive from our clinics, you may be eligible for free or discounted services.

Patients applying for financial assistance must exhaust all options available to them for insurance coverage including, but not limited to, applying for Medicaid coverage prior to receiving financial assistance.

If you participate in any of the following programs we will not need to see your tax information or pay stub, but will need proof that you are currently enrolled.

- Food Stamp Program
- Family Investment Program
- County Relief Programs
- Medically Needy Program
- UnityPoint – Des Moines Financial Assistance
- Iowa Family Planning Network
- Mercy – Des Moines Financial Assistance
- Mothers and Children Program (MAC)

Eligibility can be applied up to one year and shall be in effect from the date of service to which a financial assistance discount is initially applied.

Financial Assistance will only be applied to those family members/individuals listed on the proof of participation of one of the programs listed above.

## APPLICANT INFORMATION

_____

FIRST NAME LAST NAME MIDDLE INITIAL

_____

ADDRESS APT# CITY STATE ZIP

DATE OF BIRTH: _____ /_____ /_____
MM DD YYYY

## CERTIFICATION AND RELEASE OF INFORMATION

I certify there is no additional insurance coverage for myself or family other than what has been presented to Des Moines University Clinic (DMU). I understand providing false information will result in denial of financial assistance. If I am entitled to any action against or settlement from third party payers or eligible for other assistance (including Medicaid), I will take any action necessary or requested by DMU to obtain such assistance and will assign to DMU, and upon receipt will pay to DMU, all amounts recovered up to the total amount of the outstanding balance on my bill. My failure to apply for such assistance or to follow through with the application process and required documentation will result in cancellation and denial of my financial assistance. Each of the undersigned hereby acknowledges that DMU may verify or re-verify any information regarding my eligibility for financial assistance through any source, including a consumer reporting agency.

I also agree to notify Des Moines University Clinic of any changes in my financial position that would impact this determination.

_____

PATIENT'S SIGNATURE DATE

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SPOUSE'S/CO-APPLICANT'S SIGNATURE DATE