



Financial Assistance Application Form

Social Security #: _____

Date of Birth: _____

Date of Application: _____

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Are you a resident of the State of Iowa? Yes No Are you a U.S. Citizen? Yes No

Are you requesting financial assistance for Mental Health Services or Substance Services

Are you currently covered under any Health Insurance plan?: Yes No

If yes, what is the name of the plan?: _____

Have you or any of your household members applied for Medicaid?: Yes No

Status of Medicaid application? Applied, waiting notice of decision

Denied coverage, due to: _____

Eligibility gap will be covered in a month

Other: _____

Please list all household members, including yourself, below:

First & Last Name	Date of Birth	Social Sec. #	Income Source	Relationship

Gross Monthly Income Details:

Number of adults in household: _____

Number of children in household: _____

Currently Employed: Yes No

Place of Employment: _____

Full-Time Part-Time Seasonal Other: _____

To continue with the application process, please complete the State of Iowa Behavioral Health Services Eligibility Form.

I certify that the information I have provided is accurate and complete. I understand I will be requested to update my information periodically and report any changes in insurance coverage as soon as possible. I acknowledge that SIMHC is utilizing federal tax dollars to assist me in receiving health care. I understand that giving false information regarding my household income is considered fraud against the United States government.

Applicant/Guarantor: _____ (Print) Date: _____

Applicant/Guarantor Signature: _____

**Note Lab/Pharmacy services are billed independently from SIMHC and are not covered by the Financial Assistance Program*

FOR OFFICE USE ONLY----Financial Assistance

Using the information provided by the Applicant and the Poverty Guideline Table, calculate the below:

Yearly GROSS family income: _____ # Persons in household _____ = _____ %PGL

In order to qualify for financial assistance, the applicant must have a %PGL of 200% or below.

_____ Eligible for assistance

_____ Not Eligible for assistance

DETERMINATION OF ASSISTANCE TYPE

① If the applicant is eligible for assistance and has NO insurance - Follow this procedure:

This person will be billed through the Iowa HHS Non-Medicaid Safety Net Management Information System (SN-MIS). This is NOT insurance, rather a way the State of Iowa will reimburse us at a reduced rate as we work with the applicant to apply for Medicaid.

Step 1: Although not a true "Insurance" in Credible we will enter it as one so the claims will go correctly.

When entering the patient insurance information, first, refer to the % of assistance calculated above then for applicants that qualify for 100% assistance, in Credible, select the insurance **IA SN-MIS**. For the Insurance ID, use their SS#. For Coverage Starts Date, use the Date of Eligibility Determination, For Coverage Ends, use 90 Days from the Date of Eligibility.

Step 2: Schedule the applicant with a Care Coordinator to assist with their Medicaid application.

② If the applicant is eligible for assistance and has insurance and is a State of Iowa Resident and is seeking financial assistance for Mental Health and not Substance- Follow this procedure:

This person is eligible for Iowa Block Grant Assistance on the Sliding Fee Scale. Using the Calculated %PGL above refer to the chart for the % of Fee due from client vs. % of Fee due from grant. Enter the amounts below.

●% of Fee due from client _____% % of Fee due from grant _____%

When entering the patient insurance information, for the Insurance select **IA DHS BLOCK GRANT**, for the Insurance ID, use their SS#, for Coverage Starts Date, use the Date of Eligibility Determination, For Coverage Ends, use 90 Days from the Date of Eligibility.

③ If the applicant is eligible for assistance and has insurance and is either not an Iowa resident **or** is seeking financial assistance for Substance treatment -Follow this procedure:

This person is eligible for SIMHC Financial Assistance on the Sliding Fee Scale. Using the Calculated %PGL above refer to the chart for the % of Fee due from client vs. % of Fee due from grant. Enter the amounts below.

●% of Fee due from client _____% % of Fee due from grant _____%

When entering the patient insurance information, for the Insurance select **SIMHC FA**, for the Insurance ID, use their SS#, for Coverage Starts Date, use the Date of Eligibility Determination, For Coverage Ends, use 90 Days from the Date of Eligibility.

Effective Date: _____ Expiration Date: _____

Authorizing Signature: _____ Date: _____

When the application is completed:

_____ Complete a "Notice of Decision" document for the applicant

_____ Notify the applicant of the results of the application in person/by phone/mail.

_____ Scan the "NOD", applications and documentation into the Credible Chart and save under the Financial folder.

_____ Email Stacey at sharland@simhcottumwa.org the Client Name, Credible ID and if the application was denied or approved.

_____ Enter an alert of the expiration date of funding in Credible under Warnings.

_____ Review the status of the "Does the Patient have CCBHC insurance?" question in the Credible Patient Profile for accuracy and update if needed.

_____ Client notified by staff Date: _____ Staff initials: _____