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| **Financial Assistance Application** | | | | | | |
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| Applicant Information | | | | | | |
| Name: | | | | | | |
| Date of birth: | SSN: | | | Phone: | | |
| Current address: | | | | | | |
| City: | State: | | | ZIP Code: | | |
| Cell Phone: | E-mail Address: | | | |
| Employment Information | | | | | | |
| Please indicate if you are Employed/Retired/Disabled: | | | | | | |
| Current employer : | | | | | | |
| Employer address: | | | | | How long? | |
| City: | State: | | | ZIP Code: | | |
| Position: | Annual income: | | | |
| HOUSEHOLD Co-Applicant Information | | | | | | |
| Name: | | | | | | |
| Date of birth: | SSN: | | | Phone: | | |
| Current address: | | | | | | |
| City: | State: | | | ZIP Code: | | |
| Employment Information | | | | | | |
| Please indicate if the co-applicant is Employed/Retired/Disabled: | | | | | | |
| Current employer: | | | | | | |
| Employer address: | | | | | How long? | |
| City: | | State: | | ZIP Code: | | |
| Position: | | Annual income: | | |
| Additional household members | | | | | | |
| Name | | Relationship to Applicant | Annual Income if applicable | | | |
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|  | |  |  | | | |
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| Accounts related to application request | | | | | | |
| Patient Name: | | Account no. | Date of Service: | | | Amount: |
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| Other Assets or Sources of Income | | |
| Description | Amount per month or value | |
|  |  | |
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|  |  | |
| I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.    I understand that this application is completed so that the hospital can determine my eligibility for uncompensated services under the hospital’s established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate. | | |
| Signature of applicant | | Date |
| Signature of co-applicant, I/A | | Date |
| Eligibility Determination  (for office use only) | |
| Date Received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Verification Completed: Yes \_\_\_\_ No \_\_\_\_ | |
| The applicant was approved for a reduction of \_\_\_\_\_\_\_% of allowable charges. | |
| The applicant was denied for the following reason(s)  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Date of Determination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Applicant Notified: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Individual Completing Review: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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**Financial Assistance Application Check List**

Verification of the following information is needed to complete your application for Financial Assistance:

* Proof of Medical Assistance application may be required if applicable
  + Proof of Income:
    - Household income
    - Income Tax Return (if applying in first three months of calendar year)
    - Pay Stubs for one month (for applications April through December)
    - Unemployment Compensation
    - Social Security verification
    - Pension
    - Workers Compensation
    - Sick Benefits
    - Self-Employment
    - Rental Income
    - Child Support
    - Interest or Dividends
    - Any other income into the household
    - MA162 with income information
  + Proof of Assets
    - Checking Account balance
    - Savings Account balance
    - Certificate of Deposit (CD)
    - US Savings Bond
    - Stocks or Bonds
    - HRA, HAS, FSA, or any medical savings account

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**Financial Assistance Guidelines:**

**Household size includes:**

Guarantor that is not claimed on another individual’s income tax

Child over 18

Disabled over 18

Emancipated Minor

**Dependents defined as:**

Applicant/Co-applicant – significant other at the time of the application

Child- income tax or proof of child support

**Automatic Eligibility:**

Patient applies for Medical Assistance and their patient pay is less than $5,000

Scoring Results

**Not Qualified:**

Cosmetic Surgery

Pre-Collection Amounts

Amish and/or like contract

If any data is misrepresented

If Medical Savings Account Exists with Balance

Self-Pay balance for greater than 240 days

Medicaid denial not related to low income, i.e. incomplete application

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**Medicaid Application**

Medicaid Applications are required for high dollar encounters, i.e. Inpatients, Observation, SDC’s (Same Day Outpatient Surgeries)

Accounts with no insurance until presumptive scoring is used for automated approvals of financial assistance for active accounts (non-bad debt).

Insurance deductibles of $1,000 or more

**Approval Period:**

Medicare eligible individual – 1 year

Non-Medicare individual - 6 months

Insurance will be deleted from demo recall based on the expiration dates.

**Disclaimer Points:**

1. ***You must apply within 240 days from date of self-pay balance or application will be denied.***
2. ***Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.***
3. ***Services considered to be personal and/or cosmetic will not qualify for Financial Assistance.***
4. ***Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance***

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