Financial Assistance/Charitable Care Determination

Dear Consumer,

Newman Memorial Hospital strives to be the best place to get care and receive care. The Hospital recognizes the financial cost associated with accessing such care. The Hospital offers the opportunity, for eligible consumers, to apply for financial assistance/charitable care determination. This service is designed to assist qualifying consumers who are in need of medical treatment the opportunity to reduce their financial obligation related to the medical services provided.

If you wish to apply for financial assistance/charitable care for those services provided to you, please complete the attached FA/CC Application and provide the required documentation needed to assess your eligibility for this program.

NMH requires the FA/CC Application and supporting documents to be returned to the Hospital's Financial Counselor, located within the Patient Business Services Department within fifteen (15) days of your official request to be considered to be eligible for this service. Eligibility is determined on an account by account basis.
If you have any questions or require assistance in the completion of the FC/CC Application, please call (580) 938-2551 Ext. 5553.

Sincerely,

NMH Financial Counselor
Newman Memorial Hospital
Phone (580) 938-2551
Fax (580) 938-2615

Financial Assistance/Charitable Care Application

______________________ ____/____/____ ____/____/____ ______________________

Patient Name | Social Security # | Date of Birth | Account #

______________________ ____/____/____ ____/____/____ ______________________

Guarantor's Name | Social Security # | Date of Birth | Relationship to Patient

Guarantor's Address | City, State, Zip | Home Phone | Length of Residence

Previous Address | City, State, Zip | Marital Status | # of Dependents in Household

List names and Ages of Dependents in Household:

Employer (Guarantor/Patient) | Previous Employer (Guarantor/Patient) | Spouse Employer

Employer (Guarantor/Patient)	Previous Employer (Guarantor/Patient)	Spouse Employer
Address	Address	Address
Job Title/Length of Employment	Job Title/Length of Employment	Job Title/Length of Employment
Business Telephone #	Business Telephone #	Business Telephone #
Hourly Rate	Hourly Rate	Hourly Rate
Monthly Income Gross	Monthly Income Gross	Monthly Income Gross
Monthly Income Net	Monthly Income Net	Monthly Income Net
Other Income Source/Amount	Total Family Monthly Income	Total Family Income Last 12 Months

Have you applied for Medicaid or any other State/County Assistance? (check one) Yes No (If denied, please attach a copy of the denial letter).

Application Date | Caseworker Name/Telephone Number

Have you filed a bankruptcy? Yes No Chapter 7 Chapter 13 Date filed ____________ Date of Discharge____________

Are you a Homeowner? Yes No Approximate $ Value ______________________

Approximate Balance on Loan ___________________ Yrs. Left on Loan ___________________________

Bank Name ______ Checking Account # ______ Avg. Checking Balance ______

Savings Account # ______ Avg. Savings Balance ______

Automobiles:

1. Make: ______ Model: ______ Year: ______ Payment Amount: ______ Balance Due: ______
2. Make: ______ Model: ______ Year: ______ Payment Amount: ______ Balance Due: ______

Other Assets (Stocks, Bonds, Property, Boat, Business, etc.)

Description	Monthly Payment	Payment To	Account #	Balance Due	Limit
Rent/Mortgage	$			$	$
Charge Cards	$			$	$
	$			$	$
	$			$	$
Bank Loans	$			$	$
	$			$	$
School Loans	$			$	$

List Other Expenses Below

	Monthly Payment		Monthly Payment		Monthly Payment
Food	$	Medication	$	Auto Insurance	$
Utilities	$	Life Insurance	$	Other	$
Gas (Car)	$	Medical Bills	$	Other	$
	Total $______		Total $______		Total $______

TOTAL MONTHLY EXPENSES $______

Note: Attach additional sheet if necessary.

Important: income verification must be attached – W-2, pay stub, tax return, etc.

CERTIFICATION

1. I, the undersigned, certify that the completed information in this document is true and accurate to the best of my knowledge.
2. I will apply for any and all assistance that may be available to help pay this bill.
3. I understand the information submitted is subject to verification; therefore, I grant permission and authorize any bank, insurance co., real estate co., financial institution and credit grantors of any kind to disclose to any authorized agent of Newman Memorial Hospital, information as to my past and present accounts, policies, experiences and all pertinent information related thereto. I authorize Newman Memorial Hospital to perform a credit check for both guarantor/patient and spouse.

Signature (Guarantor/Patient)______ Date______ Witness______ Date______

Signature (Spouse)______ Date______ Witness______ Date______

DIRECTIONS FOR COMPLETING FINANCIAL ASSISTANCE APPLICATION

1. Complete the patient name, patient's social security number, patient's date of birth, and the hospital account number(s) if known.
2. Complete the guarantor name, relationship to patient, guarantor's date of birth, and guarantor's social security number. If the guarantor is the same as the patient, note "Same" in this field.
3. Complete the guarantor's address, home telephone number and length of residence at this address.
4. Complete the guarantor's previous address (if current residence is less than two years), guarantor's marital status, and number of dependents living in household. If there are no dependents, please mark "-0-"in the dependent field.
5. List the names and ages of dependents.
6. Complete the employer information for the guarantor or patient, depending upon who has responsibility for the balance. Please complete the name of the employer, the employer's address, the guarantor/patient's job title and length of employment. Please also include the guarantor/patient's business telephone number, hourly (or salary) rate, and the monthly income (both gross and net). If there is no employment, please note how expenses are being met.
7. Complete the previous employer information for the guarantor/patient. This includes the employer's name and address, the guarantor/patient's job title and length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If there is no prior employment, mark "N/A."
8. Complete the income information for the guarantor/patient's spouse. Include the name of the employer, the employer's address, job title/length of employment, business telephone number, hourly rate, and monthly income (both gross and net). If the spouse is unemployed, or there is no spouse, mark "N/A."
9. Complete the other income source/amount. This is for child support, social security, bonus amounts from employers, etc. This also includes rental income, alimony, pension income, welfare and VA benefits. Complete the total family income (add the guarantor/patient net income), then complete the total family income from the last 12 months. If there has been no income, please note how expenses are being met.
10. Complete the questions regarding Medicaid and other State/County assistance. Please advise if you have applied for assistance (and on what date). Please provide the assigned Caseworker's name and telephone number. You may attach a separate sheet if needed. Please mark N/A if this field does not apply to you.
11. Please indicate if you have ever filed bankruptcy. If you have not filed bankruptcy, please mark "No." Please verify that all questions have been completed. Attach additional paper if needed for any explanations.
12. Please complete the homeowner information. If you are a homeowner, please note the approximate dollar value, the approximate balance on the loan, and the number of years left on the loan. If you are not a homeowner, please mark "No."
13. Please complete the banking information as requested and list the bank name. Complete the checking account number and provide the average checking account balance. Please do the

same for the savings account field. If there is no savings account, please place "N/A" in the savings field.

14. For automobile information, please list the make, model and year of your vehicle. Please list the monthly payment amount and the current balance.
15. Please complete the section listing other assets you may have. This includes stocks, bonds, property, boats and businesses you may own. Use additional paper if needed to give complete details. If there are no additional assets, please mark "N/A."

HOW TO COMPLETE THE MONTHLY EXPENSE SECTION

Rent/Mortgage: Please verify the amount you are paying in rent or by mortgage. Indicate to whom the payment is made, the account number and the current balance due. If you do not pay rent or mortgage, please note why you have no payment or if you live with relatives or others. Use additional paper if needed. Please enclose the previous 3 months of rent/mortgage or clarify on bank statement.

Charge Cards: Please indicate any charge card payments you are currently making. Please indicate the monthly payment amount, to which the payment is made, the account number and the current balance due. Please indicate the credit limit for each card. Use additional paper if needed to complete this field. If you have no charge cards, please note "N/A."

Bank Loans: Please indicate any bank loans you may be paying. Indicate the monthly payment amount, to which the payment is made, the account number and the current balance due. Use additional paper if needed to fully explain this field. If you have no bank loans, please mark "N/A." Please enclose the previous 3 months of bank statements.

School Loans: Please list any educational loans you may be paying. This can include, but not be limited to, college loans, private school loans (or tuition), day-care expenses or any other loans that apply to education. Please use additional paper if needed. Please specify if you are paying school loans, etc. If this does not apply to you, please mark "N/A."

LIST OTHER MONTHLY EXPENSES:

Food: Please list the amount paid for food on a monthly basis.

Utilities: Please list the amount paid on a monthly basis for electricity, gas, water, trash and any other utility you may pay. Pleas add these and place the total (for all of them) in the utilities section. If there are no monthly utilities paid, please mark "N/A" and explain. Use a separate sheet of paper if needed. Please enclose the previous 3 months of utility bills or clarify on bank statement.

Gas (Car): Please list the amount paid on a monthly basis for transportation needs related to your vehicle. If there is no payment made on a monthly basis for gas, please mark the field "N/A."

Medication: Please add the amounts you pay on a monthly basis for medication needs. If there are several prescriptions or medications you take, please add them together and place the total amount in this section. If there are no monthly medication payments, please place "N/A" in this section.

Life Insurance: If you have a life insurance policy, please indicate the monthly amount you pay. If there is no payment, please place "N/A" in this section.

Medical Bills: Please add any medical bills you may be paying on a monthly basis. This may include, but not be limited to, physician bills, insurance co-pays, insurance deductibles, other hospital bills, radiology bills, ambulance bills, etc. Please use a separate sheet of paper to list these amounts. Add them together and place the total amount in this section. If there are no monthly medical payments being made, please place "N/A" in this section.

Auto Insurance: Please place the total amount you pay on a monthly basis for auto insurance. If you pay on a quarterly basis, please divide the quarterly payment by 3 and place the amount in this section. If you pay every 6 months, please divide the total amount you pay by 6 and place the amount in this section. If there is no monthly payment being made, please mark "N/A?"
Other: This includes any monthly payments you currently are making that are not listed in the previous sections. Please provide details of what you are paying, to whom, and the balances due. Please use a separate sheet of paper if needed. If this section doesn't apply to you, mark "N/A."

Total Monthly Payments: Please total all the above payments and place the amount in this section.

DOCUMENTS NEEDED TO JUSTIFY INCOME

Copy of Bank Statement and/or Pre-Paid Credit Card statement with income deposits.
If social security income: copy of check or a copy of bank statement showing most recent social security check deposit.
If unemployed: verification of any compensation received. Example: unemployment compensation, workers compensation, etc.
If unemployed and receive no income: a letter of support written by the person or persons who are providing financial support.
If assistance from City Welfare: vouchers from each program that provides assistance to the individual. Example: food stamps, rental subsidy, fuel assistance, etc.
If child support and/or alimony are provided: copies of checks.

PLEASE READ THE FINE PRINT

Documentation: Please notice that your signature indicates you have agreed to attach all income verification. In addition to the items requested by this application, you may attach bank statements, copies of social security checks (or letters). If there is no income, please verify how expenses are being met. It is important to explain a lack of income completely so that full consideration of your application can be made. If the guarantor/patient or the spouse is self-employed, please attach the last 2-3 months of bank statements. All documentation must be attached for full consideration. If the application is incomplete, it will be returned. We will not be responsible for follow-up on incomplete applications.

WHAT YOU ARE AGREEING TO:

1. Stating that the guarantor/patient has completed this form accurately.
2. Stating that the guarantor/patient will apply for any assistance to pay this bill. This may include acquiring a bank loan or putting the balance on your credit card.
3. Authorizing Newman Memorial Hospital to obtain credit information and perform a credit check.

FINANCIAL ASSISTANCE CHECKLIST

INFORMATION REQUIRED FOR COMPLETE APPLICATION (Check if yes)

- ☐ The demographic information is completed for patient and guarantor (i.e., address, etc.).
- ☐ The dependent information is completed (i.e., number in household, names, ages, etc.).
- ☐ The employment and income information is completed for the patient/guarantor and spouse.
- ☐ A copy of most recent year's IRS Tax Return is attached.
- ☐ A copy of most current pay stub is attached.
- ☐ If no income is documented, attach an explanation for how expenses are being met.
- ☐ If the patient/guarantor has filed bankruptcy, all questions are answered.
- ☐ If the patient/guarantor is a homeowner, all questions are answered.
- ☐ Information is completed for banking information (i.e., checking and savings accounts).
- ☐ Information is completed for automobile.
- ☐ Information is completed for other assets.
- ☐ Rent and utility receipts for the past 3 months.
- ☐ The expense/monthly payment information is completed.
- ☐ Does all information look reasonable?
- ☐ Are there any luxurious items listed that might prevent patient/guarantor from paying the bill (e.g., country club dues, maid or lawn service, boat, high cable bills, etc.)?
- ☐ Has the patient/guarantor and spouse signed and dated the form?
- ☐ Has the witness signed and dated the form?
- ☐ Compare the Total Family Monthly Income to the Total Monthly Expenses. Can the patient/guarantor afford to make monthly payments? If so, contact the patient/guarantor to establish payment arrangements. **STOP**.
- ☐ If the patient/guarantor cannot afford monthly payments, use the FPL Guidelines to determine if the patient/guarantor qualifies for Financial Assistance.
- ☐ If the patient qualifies for Financial Assistance, forward all information to Business Office Manager to review and approve.
- ☐ If the patient does not qualify for Financial Assistance, send denial for Financial Assistance letter to patient/guarantor.
- ☐ If the application is incomplete, return application and all supporting documentation to patient with a letter indicating what is required and that it needs to be returned.
- ☐ The Business Office Manager needs to approve and forward to the CFO all discounts over $5,000 for approval.
- ☐ The Business Office Manager will return all supporting documentation to the Financial Representative to send acceptance for a Financial Assistance letter to the patient and to enter information on the Charity Log.
- ☐ The Financial Account Representative will enter the percentage of charity eligibility on the account and send a reminder to the CFO.
- ☐ The Financial Representative will send an acceptance for Financial Assistance letter to the patient and file.
- ☐ The Business Office Manager selects this chart for Quality Review.

____________________________________ ________________

Signature – Financial Representative Date

____________________________________ ________________

Signature – Financial Representative Date

Application Form – Presumptive Eligibility

My name is (please print): ______________________ ______________________ ____

Last First M.I.

I am: The Patient The Patient's Guarantor

Neither (Please state your relationship to the Patient: ______________________)

Instructions:

1. ***Please indicate that the Patient is eligible for charity care discount because the Patient is in one or more of the following categories.***
2. ***More than one copy of this form may be required if it is to be completed by more than one individual (e.g., Patient, Guarantor, etc.).***

#	Is category applicable?		Is relevant document attached?		
1.	yes	no	yes	no	Patient has received care from and/or has participated in Women's, Infants and Children's (WIC) programs.
2.	yes	no	yes	no	Patient is homeless and/or has received care from a homeless clinic.
3.	yes	no	yes	no	Patient is eligible for and is receiving food stamps.
4.	yes	no	yes	no	Patient's family is eligible for and is participating in subsidized school lunch programs.
5.	yes	no	yes	no	Patient qualifies for other state or local assistance programs that are unfunded or the patient's eligibility has been dismissed due to a technicality (i.e., Medicaid spend-down).
6.	yes	no	yes	no	Family or friends of a patient have provided information establishing the patient's inability to pay.
7.	yes	no	yes	no	The patient's street address is in an affordable or subsidized housing development.
8.	yes	no	yes	no	Patient/guarantor's wages are insufficient for garnishment, as defined by state law.
9.	yes	no	yes	no	Patient is deceased with no known estate.
10.					Other – ***Provide explanation*** ______________________

Signature ______________________ Date__________

Authorized by: ______________________ Title: __________ Date__________

Notification of Determination:
After determining the patient's eligibility for financial assistance/charity care, the patient will be notified, by the organization Financial Councilor, in writing of the determination. If possible, verbal notification will be provided as well.

Eligibility of Financial Assistance/ Charity Care:
Though Financial Assistance/Charitable Care is approved on a "per occurrence basis", NMH will maintain the application and records of consumers who apply for Financial Assistance/Charitable Care for a period of twenty-four (24) months. Individuals needing to apply for reoccurring assistance will only need to provide updated information concerning their financial status. NMH reserves the right to require consumers to complete the full application process each time the consumer is applying for Financial Assistance/Charitable Care.

THIS SECTION IS PURPOSFULLY LEFT BLANK

Financial Assistance Sliding Scale

Based on 2019 U.S. Federal Poverty Guidelines

	Poverty Guidelines					
Number In Household	**0-138%**	**138-150%**	**151-200%**	**201-250%**	**251-300%**	**301-400%**
1	$16,753	$18,210	$24,280	$30,350	$36,420	$48,560
2	$22,715	$24,690	$32,920	$41,150	$49,380	$65,840
3	$28,676	$31,170	$41,560	$51,950	$62,340	$83,120
4	$34,638	$37,650	$50,200	$62,750	$75,300	$100,400
5	$40,600	$44,130	$58,840	$73,550	$88,260	$117,680
6	$46,561	$50,610	$67,480	$84,350	$101,220	$134,960
7	$52,523	$57,090	$76,120	$95,150	$114,180	$152,240
8	$58,484	$63,570	$84,760	$105,950	$127,140	$169,520
Per Additional Person	$5,961	$6,480	$8,640	$10,800	$12,960	$17,280
Percentage of Charges Discounted	**100%**	**95%**	**90%**	**85%**	**80%**	**The cost of services as determined by multiplying the NMH cost to charge ratio by the billed charges.**

REFERENCES

Patient Protection and Affordable Care Act, Section 9007(a)
Internal Revenue Code, Section 501(r)
The Poverty Guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2). Effective January 11, 2019.