

Community Care *Financial Assistance Program*

Policy and Procedures

It is the policy of Ministry Health Care and its affiliated entities to provide medically necessary health care services to people in the communities it serves, regardless of their ability to pay. Community Care financial assistance is granted based upon the patient's inability to pay and to individuals who are uninsured, underinsured or medically indigent. Financial assistance is not available for "non-medically necessary procedures."

Community Care works in collaboration with other financial (both public and private) assistance programs. This is to ensure holistic wellness of patients by facilitating knowledge of available services and programs for health, while practicing good stewardship of funds. Key criteria utilized to determine eligibility for Community Care financial assistance includes family size, federal poverty income guidelines and available assets.

In accordance with Ministry Health Care's values, staff will treat patients and family members with compassion, dignity and respect at all times during

the Community Care process. All patient and proprietary information is considered confidential and protected by law. Ministry Health Care will safeguard the privacy and security of patient protected health information. Access to patient and/or proprietary information is determined by a "need-to-know" and as minimum necessary to carry out duties or assignments. Ministry Health Care assures that services and programs are equally available to everyone; immigration status will not be reported to federal agencies.

Community Care patients must complete an application form and supply all necessary information required to make a determination for financial assistance eligibility. The same application form will be utilized by all applicable Ministry Health Care organizations. The application form will be subject to periodic verification of the individual or family's current financial status. If a patient believes a denial for Community Care was made in error, the patient may appeal the decision in writing.

Applicant Responsibilities

It is an expectation that the patient/guarantor will cooperate and supply all necessary information required to make a determination for Community Care financial assistance eligibility (applications may be re-evaluated every six months).

No single organization can meet the needs of all patients who are unable to pay. Community Care works in collaboration with other financial (both public and private) assistance programs. Patients will be asked to pursue all other assistance options for which they may be eligible prior to their evaluation for Community Care financial assistance.

Dear Patient:

*Attached is an application (Financial Statement) for our Community Care program. Guided by the mission and values of Ministry Health Care, Community Care is available to eligible patients who are unable to pay all or part of their hospital and/or physician charges based on financial need. In order to consider you for Community Care, **all the documents listed on the following Documentation Checklist must be provided.** If you cannot provide any of the requested documentation, please indicate the reason(s).*

We encourage you to return the financial statement along with supporting documentation within 14 days. We will review your information and contact you within 30 days. If you have any questions about this financial assistance program or application requirements, please feel free to contact us.

DOCUMENTATION CHECKLIST



Patient's Name _____

Date _____

FINANCIAL STATEMENT

Must Be Provided

Please print all information clearly and carefully. If the line does not apply, please write "NA" (not applicable) or "0" (zero) on the line.

STATE AND COUNTY ASSISTANCE

Documentation from your county Social Services Department for medical programs.

Provided Not Provided

If not provided, list reason(s) why: _____

UNEMPLOYMENT COMPENSATION

If you have received Unemployment Compensation in the last 12 months, please provide verification of the amount and include start and stop dates.

Provided Not Provided

If not provided, list reason(s) why: _____

TAX STATEMENTS

If you owned property in the past year, or if you were responsible for personal property taxes, please provide a copy of the previous year's tax bill or statement(s).

Provided Not Provided

If not provided, list reason(s) why: _____

FEDERAL INCOME TAX

Provide complete copy of previous year's Federal Income tax form including all schedules filed and W2s.

Provided Not Provided

If not provided, list reason(s) why: _____

DOCUMENTATION CHECKLIST *(continued)* **INCOME VERIFICATION/SOCIAL SECURITY BENEFITS**

Provide proof of income from past 12 months including most recent paycheck stub and last two bank statements.

If you receive Social Security benefits, please include a copy of one of the following:

- (a) yearly statement showing the amount of your monthly benefits, *OR*
- (b) Social Security check, *OR*
- (c) bank statement showing the direct deposit amount.

 Provided **Not Provided**

If not provided, list reason(s) why: _____

 CHILD SUPPORT/ALIMONY

If you are paying/receiving child support/alimony, please send a copy of check stubs for the past 12 months or County Social Services Child Support Office statement.

 Provided **Not Provided**

If not provided, list reason(s) why: _____

 HEALTH CARE EXPENSES

If you have required medications in the past 12 months, provide documentation from pharmacy verifying your out-of-pocket expenses. Also, If you pay after-tax insurance premiums, please provide a recent billing statement.

 Provided **Not Provided**

If not provided, list reason(s) why: _____

Completed Financial Statement and supporting documentation should be mailed or hand-delivered to the Community Care Contact where the patient received care.

Patient's Name Date

Medical Record # OR Date of Birth Address

Have you applied at any other Ministry Health Care facility recently? Yes No If yes, where?

Demographic Information	Responsible Party <input type="text"/>	Date of Birth <input type="text"/>	Spouse <input type="text"/>	Date of Birth <input type="text"/>
	Address <input type="text"/>			Time at present address: ____ Years ____ Months <input type="checkbox"/> Own <input type="checkbox"/> Rent
	City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>	Number of household members <input type="text"/>
	Telephone number (with area code) <input type="text"/>		County <input type="text"/>	Names of other household members <input type="text"/>
				Ages <input type="text"/>
				<i>List additional names and ages under "Additional Information" on page 8.</i>

Patient

Social Security Number

Employer

Business Address/Phone

Occupation

Length of Employment Hourly Wage \$ Hours worked per week

Spouse

Social Security Number

Employer

Business Address/Phone

Occupation

Length of Employment Hourly Wage \$ Hours worked per week

Income Sources – Monthly Gross (Before Taxes)

Monthly Gross (Before Taxes) Income \$

Social Security \$

Public Assistance \$

Rental Income \$

Retirement/Pension \$

Veterans Benefits – Are you a veteran or entitled to veteran's benefits? Yes No \$

Unemployment/Workers Compensation From to \$

Child Support/Foster Care/Alimony \$

Disability \$

Other: \$

TOTAL \$

Monthly Gross (Before Taxes) Income \$

Social Security \$

Public Assistance \$

Rental Income \$

Retirement/Pension \$

Veterans Benefits – Are you a veteran or entitled to veteran's benefits? Yes No \$

Unemployment/Workers Compensation From to \$

Child Support/Foster Care/Alimony \$

Disability \$

Other: \$

TOTAL \$

TOTAL Combined Monthly Gross Income \$
 If zero or no income, please explain how you provide for your living expenses:

I am claimed as a dependent by another individual on their income tax filing. Yes No
 If yes, provide name and relationship:

FINANCIAL STATEMENT – Page 2

ASSETS/Savings – Joint	Bank/Location	Amount/Value
Checking Account(s)	<input type="text"/>	\$ <input type="text"/>
Savings Account(s)	<input type="text"/>	\$ <input type="text"/>
Certificate of Deposit (CD)	<input type="text"/>	\$ <input type="text"/>
Stocks/Bonds	<input type="text"/>	\$ <input type="text"/>
Other (IRAs/Mutual Funds/401K)	<input type="text"/>	\$ <input type="text"/>

ASSETS/Property	Homestead Address		Assessed Value \$ <input type="text"/>	Mortgage Balance \$ <input type="text"/>	
	Township, County		Lien Holder	Mortgage Payment \$ <input type="text"/>	
	Motor Vehicle #1: Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Motor Vehicle #2: Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Motor Vehicle #3: Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Motor Vehicle #4: Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Recreational Equip. #1 (boats, snowmobiles, etc.): Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Recreational Equip. #2 (boats, snowmobiles, etc.): Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Recreational Equip. #3 (boats, snowmobiles, etc.): Year, Make and Model	Value \$ <input type="text"/>	Loan Balance \$ <input type="text"/>	Lien Holder	Payment \$ <input type="text"/>
	Other Property #1: Address, Township and County	Loan Balance \$ <input type="text"/>	Assessed Value \$ <input type="text"/>	Payment \$ <input type="text"/>	
Other Property #2: Address, Township and County	Loan Balance \$ <input type="text"/>	Assessed Value \$ <input type="text"/>	Payment \$ <input type="text"/>		
Other Property #3: Address, Township and County	Loan Balance \$ <input type="text"/>	Assessed Value \$ <input type="text"/>	Payment \$ <input type="text"/>		
Other Property #4: Address, Township and County	Loan Balance \$ <input type="text"/>	Assessed Value \$ <input type="text"/>	Payment \$ <input type="text"/>		

FINANCIAL STATEMENT – Page 3

Monthly EXPENSES	Rent \$ _____	Renter's/Homeowner's Insurance \$ _____	Transportation Cost \$ _____	Cable TV/Satellite \$ _____
	Phone/Cell Phone \$ _____	Alimony/Maintenance \$ _____	Child Support \$ _____	Child Care \$ _____
	Electric \$ _____	Auto Insurance \$ _____	Food \$ _____	Other: _____ _____
	Heat \$ _____	Life Insurance \$ _____	Property Taxes \$ _____	\$ _____
	Water & Sewer \$ _____	Health Insurance \$ _____	Medications \$ _____	TOTAL \$ _____

Charge Accounts & Other EXPENSES	Creditor Name	Address	Balance	Payment
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
			TOTAL \$ _____	

Medical EXPENSES	Creditor Name	Address	Balance	Payment
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
	_____	_____	\$ _____	\$ _____
			TOTAL \$ _____	

COMBINED TOTAL Expenses (monthly, charge accounts, medical and other) \$ _____

FINANCIAL STATEMENT – Page 4
Additional Information

Have you applied for any state/county assistance program? Yes No

If Yes, Program _____
 County _____
 Date Applied _____ Application: Accepted Denied Pending

Please comment on any other items regarding your financial situation which you feel should be taken into consideration in the determination of your application.

I authorize Ministry Health Care to verify any information given on this financial statement. I attest that the above information is accurate to the best of my knowledge and truly represents my current financial status. This financial information, along with information obtained through the verification process, may be shared with the physicians providing my care for sole purpose of determining if physician services would be provided at a discounted rate. I understand that physicians are private contractors and their charges might not be part of this Community Care Program.

I understand that I am expected to maintain coverage under any other health insurance programs for which I am eligible, and that failure to do so may result in loss of eligibility for Community Care assistance.

I understand that if this application is granted, some or all of the costs of my medical care will be paid by Ministry Health Care’s Community Care Financial Assistance program. If I receive payment from any other source compensating or reimbursing me for the costs of my care, I will promptly notify Ministry Health Care. In addition, I will repay Ministry Health Care for the costs of my care paid for by the program, up to the full amount of the payment I receive from any other source.

I will also notify Ministry Health Care if I receive or have a right to receive any proceeds of a legal settlement or judgment that relates to the events that gave rise to my medical care at Ministry Health Care. By signing this application, I give Ministry Health Care the right to recover from any settlement or judgment proceeds, an amount equal to the costs of my care that were paid by the program.

 Patient’s (or guarantor) Signature

 Date

Note: If documentation is not enclosed, application may not be considered.

APPEAL FORM



Patient's Name	Medical Record # OR Date of Birth
Address (Street, City, State and Zip)	Telephone Number (with area code)
If home care or hospice, list agency name and location	
If you have been denied for partial or full community care assistance, would you like to request an extended payment arrangement to pay off your account balances? <input type="checkbox"/> Yes <input type="checkbox"/> No	

FINANCIAL CHANGE(S)

Please describe any financial changes that have occurred since the completion of your community care application. How have your income, assets and/or expenses changed? Do you have additional expenses?

Describe changes:	Previous	Current
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

OTHER REASONS FOR APPEAL

Are there other reasons or circumstances that we should reconsider your Community Care Financial Assistance Program application? Please attach additional documentation or verification of financial changes noted above.

Patient's (or guarantor)Signature _____
Date

Date Received: _____ **APPEAL REVIEW:** FULL REDUCTION PARTIAL REDUCTION NO CHANGE

Community Care *Financial Assistance Program*

Frequently Asked Questions

What if I can't pay my medical bill?

If your services were provided at a Ministry Health Care facility, you may be eligible for Community Care Financial Assistance. However, patients are asked to pursue all other assistance options before seeking financial assistance from Ministry Health Care.

Why do I need to look for other sources of funding before I receive financial assistance?

No single organization can meet the needs of all patients who are unable to pay. Community Care works in collaboration with other financial (both public and private) assistance programs. This ensures Ministry Health Care resources will be available to patients who don't qualify for other financial help.

How do I find out about other sources of funding?

It is always difficult to know where to start because of the complexity of programs, but a good place to begin is by contacting the county Social Services Department. A more comprehensive list of resources can be found online at:

<http://covertheuninsured.org/stateguides>

What determines the financial assistance I'll receive?

You will be providing information about your income, assets and family size that will determine the level of assistance.

Can I still apply for financial assistance if I've already received my medical bill?

Yes. Patients are strongly encouraged to apply for financial assistance before they receive care. However, you can apply for assistance even if your bill is past due.

Who do I contact if I have more questions?

For more information about Community Care, please call the telephone number listed on your billing statement(s) and ask to speak with a Financial Counselor. If you have not yet received a bill, please contact the Patient Account Services Department (billing office) and ask to speak with a Financial Counselor.