Billing and Collection - Policy & Procedures

Subject:	**Financial Hardship**
Effective:	**January 2017**
Revised/Reviewed:	**November 8, 2018**

***Policy*:**

If patients have recently experienced a life changing event that is contributing to their inability to pay for services, the patient can write and submit a letter describing the issue. Each letter will be reviewed by Senior AR Director and the unit to determine if patient qualifies for a financial hardship.

***Procedures*:**

In attempt to collect patient responsible balance due, the patient will receive three statements and three telephone calls regarding balance due. Patient contacts Customer Service and/or Patient Collector to discuss balance. Customer Service and/or Patient Collector will discuss financial counseling options including but not limited to financing and payment plans. If patient expresses a concerns with an inability to pay due to financial hardship patient will be provided instructions of where to mail a letter describing their circumstances.

The letter is given to the AR Director and shared with the unit Administrator to decide if financial hardship is approved. Once approved the balance is adjusted and communication is sent back to the patient.

QUALIFYING FOR HELP

If the patient receive emergency or medically necessary services and do not have medical coverage from a commercial insurer or governmental program, they may qualify for financial assistance. The amount of assistance depends on the patient's annual income and family size. If their annual income is equal to or less than 200% of the current Federal Poverty Guidelines they will not have to pay their bill.

2018 Federal Poverty Guidelines	
Household size	200% of Poverty
1	$24,280
2	$32,920
3	$41,560
4	$50,200
5	$58,840
For each additional person, add $8,640	

If the patient's income does not meet the guidelines to have your entire bill paid, they may still qualify for help paying part of their bill. However, the patient may also qualify based on other factors on their application.

Women's Care FLORIDA

FINANCIAL ASSISTANCE APPLICATION

(All fields must be completed unless noted otherwise)

Account #: _____

Patient Last Name, First	Date of Birth	Social Security Number	*Number of People in Household	Last 12 Months Annual Household Income
				$
If Minor, Guarantor's Last Name, First	Date of Birth	Social Security Number	Guarantor's Source of Income	

Vehicles in Household including Cars/Boats/RV's (Year/Make/Model)	Checking/Savings Account Balance	Properties Owned and Values	CD/Retirement/ Investment Account Balances	Other Assets
(Optional)	(Optional)	(Optional)	(Optional)	(Optional)

Patient Street Address	Home Phone Number	If income is $0, please check one:

Please read before signing. I CERTIFY that the information I have provided is true and accurate to the best of my knowledge. I will independently or with the assistance of hospital personnel apply for ANY and ALL ASSISTANCE, which may be available through federal, state, local government and private sources to help pay this hospital bill. I understand that if I do not cooperate with my hospital provider in providing requested information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Medicaid program to disclose to my hospital provider ALL information regarding the status of my Medicaid application and if the application is not approved and the reason for disapproval. I will ASSIGN to my hospital provider ALL FUNDS received from the above sources, which are provided to help with this HOSPITAL BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain in strictest confidence any written communication and/or oral discussions between me and my hospital provider regarding matters relating to services provided to me by my hospital provider. I understand that the information which I submit is subject to verification by my hospital provider, including credit reporting agencies, and subject to review by FEDERAL and/or STATE AGENCIES and others as required. I AUTHORIZE my employer to release to my hospital provider my proof of income. I UNDERSTAND that if any information I have given proves to be untrue, my hospital provider will re- evaluate my financial status and take whatever action becomes appropriate. Florida Statute s.817.50 (1). Whoever shall, willfully and with intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or s.775-083. **To qualify for assistance, at least one piece of supporting documentation that verifies household income may be required. Supporting documentation can include but is not limited to, most recent year's tax return, a current W-2, notarized letter of support, etc. Requests for assistance may be denied if supporting documentation is not provided. Any unpaid balance will be eligible for further collection action.**

			Lives with Relative(s)
City, State, Zip Code	Alternate Phone Number		Lives with Friend(s)
			Retired
Number of children under age 21 in the home: _____			Unemployed
			Disabled
			Homeless

For assistance with this application, please call (813) 286-0033 Option 3.

Signature of Applicant /Guarantor

Date Completed

* When calculating the number of people in the household, only the following people are counted: 1) Blood relatives living in the home, 2) Relatives by marriage living in the home, and 3) Relatives by legal adoption living in the home.

For Office Use Only				
Reason for Service	GAI	DOS	Family Size	Total Charges
☐ 1.0x $	☐ 1.5x $	☐ 2.0x $	☐ 25% Rule $	
Recommendation for account disposition				
Finance Committee Disposition				
_____ Manager	_____ Date	_____ Director		