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POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: The Johns Hopkins Hospital (JHH), and Johns Hopkins Bayview Medical Center, Inc. (JHBMC)

Purpose

It is the policy of the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. JHHS hospitals will publish the availability of charity care on a yearly basis in their local newspaper and will post notices of availability at appropriate intake locations. Notice of availability will also be sent to patients on patient bills.


Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing (including any accounts having gone to bad debt within 3 months of application date;) and any projected medical expenses.

PROCEDURES

1. An evaluation for Financial Assistance can be commenced in a number of ways.

For example:


- A patient with a self-pay balance due notifies the self-pay collector that he/she cannot afford to pay the bill and requests assistance.
 - A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
 - A physician or other clinician refers a patient for charity care evaluation for potential admission.
2. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, JHOPC first floor administrative staff, Customer Service, etc.
 3. When a patient requests Financial Assistance, the staff member who receives the request will refer the patient to the designated person in their clinical or business unit, who will meet with the patient. An assessment will be done to determine if patient meets preliminary criteria for assistance.
 - a. All hospital applications submitted will be processed within two business days of receipt and a determination will be made as to probable eligibility. In order to determine probable eligibility applicant must provide family size and family income (as defined by Medicaid regulations). A notice of conditional approval will instruct the applicant of the documentation necessary to complete the application process for a final determination of eligibility.
 - b. Applications received will be faxed daily to the JHHS Patient Financial Services Department's dedicated financial assistance application line for review and issuance of a written determination of probable eligibility to the patient.

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4. The following criteria must be met in order for a review for a final determination for a Financial Assistance adjustment:
 - a. The patient must apply for Medical Assistance unless the financial representative can readily determine that the patient would fail to meet the disability requirement. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
 - b. Review viability of offering a payment plan agreement.
 - c. Consider eligibility for other resources, such as endowment funds, outside foundation resources, etc.
 - d. The patient must be a United States of America citizen or permanent legal resident (Must have resided in the U.S.A. for a minimum of one year).
 - e. All insurance benefits have been exhausted.

5. There will be one application process for all of Johns Hopkins Medicine. The patient is required to provide the following:
 - a. A completed Financial Assistance Application.
 - b. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return, and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).
 - c. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
 - d. A Medical Assistance Notice of Determination (if applicable).
 - e. Proof of US citizenship or lawful permanent residence status (green card).
 - f. Proof of disability income (if applicable).
 - g. Reasonable proof of other declared expenses.

6. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor taking the application will review and analyze the application and forward to the Patient Financial Services Department for final determination of eligibility based on JHMI guidelines.
 - a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Counselor will recommend the patient's level of eligibility.
 - b. If the patient's application for Financial Assistance is based on excessive medical expenses or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Financial Assistance Evaluation Committee. This committee will have decision-making authority to approve or reject applications for charity care. It is expected that an application for Financial

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Assistance, which is reviewed by the Committee will have a final determination made no later than 30 days from the date it was considered complete. The Financial Assistance Committee will perform its evaluation of financial need based on CPA, JHH and BMC guidelines.

7. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.
8. A department can continue using an adjustment to total charges (sliding scale) without the completion of Financial Need Assessment paperwork if the sliding scale gives adjustment, which is consistent with the Adjustments and Courtesy for Clinical Services policy. The use of a sliding scale in this manner only applies to the specific service involved. It does not automatically apply to any other services.
9. A department can continue to use a government sponsored application process and associated income scale, as it is required by terms of a program grant or other outside authority governing that program. (e.g. JHBMC Addiction Treatment Services).
10. Once a patient is approved for Financial Assistance, it is expected that the patient will continue to meet his/her required financial commitments to Johns Hopkins. If a patient is approved for a percentage allowance due to financial hardship and the patient does not make the required initial payment within 60 days towards their part of the bill, the Financial Assistance allowance will be reversed and the patient will owe the entire amount. It is recommended that the patient make a good faith payment at the beginning of the Financial Assistance period.
11. Any payment schedule developed through this policy will ordinarily not exceed two years in duration. In extraordinary circumstances, a payment schedule may extend to three years in duration, with the approval of the designated director.

REFERENCE¹

JHHS Finance Policies and Procedures Manual

Policy No. FIN017 - Signature Authority: Patient Financial Services
Policy No. FIN033 - Installment Payments


Charity Care and Bad Debts, AICPA Health Care Audit Guide

Federal Poverty Guidelines (Updated annually) in Federal Register

RESPONSIBILITIES - JHH, JHBMC

Financial Counselor (Pre-Admission/Admission/In-House/Outpatient) Customer Service	Understand current criteria for Assistance qualifications.
Collector Admissions Coordinator	Identify prospective candidates; initiate application process. (BMC Community Psychiatry completes the "Application for Financial Hardship and Fee Adjustment" form)
Any Finance representative designated to accept applications for Financial Assistance	On the day preliminary application is received, fax to Patient Financial Services Department's dedicated fax line for

¹ NOTE: Standardized applications for financial assistance have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibit A.

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determination of probable eligibility.

Review preliminary application and make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.

Review and ensure completion of final application.

Deliver completed final application to appropriate management.

Document all transactions in all applicable patient account's comments.

Identify retroactive candidates; initiate final application process.

Review and ensure completion of final application.

Deliver completed final application to Patient Financial Services management.

Document all transactions in all applicable patient account's collection record.

Management Personnel
(Supervisor/Manager/Director)

Review completed final application; determine patient eligibility; communicate final written determination to patient.

Advise ineligible patients of other alternatives available to them including Medical Assistance, installment payments, bank loans, or consideration under the catastrophic program. [Refer to Appendix B - Catastrophic Financial Assistance Guidelines.

Financial Management Personnel
(Senior Director/Assistant Treasurer or affiliate equivalent)
CPP Director and Management Staff

Review and approve Financial Assistance applications in accordance with signature authority established in JHHS Finance Policy No. FIN017 - Signature Authority: Patient Financial Services.

SPONSOR

Vice President/Chief Financial Officer and Treasurer, JHHS


REVIEW CYCLE

Three (3) years

APPROVAL

President, JHHS/JHH

Date


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PROCEDURES - JHH

1. Financial Counselor/Patient Financial Services Representative/Counselor
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance. Determine possible eligibility for Financial Assistance as early in the account cycle as possible in cases where identification of Financial Assistance patient was not made before services were provided.
 - d. Initiate the Financial Assistance Application process with the patient/guarantor. As necessary, assist patient/guarantor in completing the application.
 - e. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
 - f. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
 - g. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to application and place in a file folder marked "Financial Assistance"; deliver file to Supervisor.
 - h. Document all transactions involving the application process.

2. Supervisor
 - a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
 - b. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
 - c. Approve/disapprove applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application, which does not meet the Financial Assistance Guidelines as set forth in Appendix A.


NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.

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- d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
 - e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - f. Initiate transactions to offset revenue on approved applications.
 - g. Scan records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.

- 3. Associate Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or, those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of charity amounts written off. Return finalized applications to Supervisor, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Director, Patient Financial Services for further action.
 - e. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.

- 4. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Senior Director, Patient Financial Services for further action.


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5. Senior Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications to the Director, Reimbursement or designated Manager for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than amounts authorized, forward to Vice President, Finance/CFO.

6. Vice President, Finance/CFO and Treasurer or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove applications; return finalized applications to Senior Director for final processing.

PROCEDURES – JHBMC


1. Financial Counselor (Inpatient and Outpatient) and Collector CPP Admissions Coordinator and Clinical Staff
 - a. Maintain and understand current guidelines qualifying patients for Financial Assistance.
 - b. Maintain supply of Financial Assistance Applications and current Federal Poverty Income guidelines from Federal Register.
 - c. Identify prospective candidates for Financial Assistance.
 - d. Initiate the Financial Assistance application process with the patient/guarantor. As necessary, assist patient/guarantor in completing the application.
 - e. Review preliminary application and communicate a determination of probable eligibility to patient within two business days.
 - f. Review completed application to ensure that all required information is present. Contact appropriate party to obtain any missing documentation.
 - g. Compile all supporting documentation (e.g., tax returns, pay stubs, bank statements, etc.); attach to the application; place in a file folder marked "Financial Assistance;" deliver file to designated Manager or responsible party.
 - h. Document all transactions in the application process.

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2. Supervisor, Patient Financial Services
CPP Director/Managers
 - a. Review applications for completeness within five (5) business days of receipt. Return incomplete applications to the responsible Financial Representative for completion of documentation, etc.
 - b. Determine eligibility for charitable Financial Assistance using available information, including application and applicable guidelines (e.g., Table for Determination of Financial Assistance Allowances).
 - c. Approve/disapprove applications according to signature authority established in Finance Policy No. FIN017. Disapprove any application, which does not meet the Financial Assistance Guidelines as set forth in Appendix A.

NOTE: Extenuating circumstances not addressed in the policy's guidelines may permit the application to be forwarded to the Director of Patient Financial Services for further consideration.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Associate Director, Patient Financial Services.
 - e. Send "Notice of Financial Assistance Determination" to the patient/guarantor. (Decisions for approval/disapproval will be made within thirty (30) business days of receiving completed application.)
 - f. Initiate transactions to offset revenue on approved applications.
 - g. File records and ensure their safekeeping. Retain all completed applications for eight (8) years following the end of the fiscal year in which the assistance need was identified.


3. Associate Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017 or, those applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Maintain system-generated report of charity amounts written off. Return finalized applications to Supervisor, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than authorized amount, forward to Director, Patient Financial Services for further action.

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- e. Reconcile monthly Financial Assistance write-offs per the automated report against monthly case files.
 4. Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized.
 - c. Return finalized applications to Associate Director, Patient Financial Services for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval for applications greater than amount authorized, forward to affiliate Senior Director, Patient Financial Services, for further action.


5. Senior Director, Patient Financial Services
 - a. Review applications according to signature authority established in Finance Policy No. FIN017, or applications forwarded because of extenuating circumstances.
 - b. Approve/disapprove applications as authorized in Finance Policy No. FIN017.
 - c. Return finalized applications to the Director, Reimbursement or designated Manager for "Notice of Financial Assistance Determination" to be sent to patient/guarantor.
 - d. If recommending approval of applications for amounts equal to or greater than amounts authorized, forward to Vice President, Finance/CFO.

6. Vice President, Finance/CFO or COO
 - a. Review applications for amounts according to signature authority established in Finance Policy No. FIN017.
 - b. Approve/disapprove applications and return finalized applications to Director, Patient Financial Services.

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**APPENDIX A
FINANCIAL ASSISTANCE PROGRAM ELIGIBILITY GUIDELINES**

1. ***Notice of the availability of the JHHS Financial Assistance Program will be posted at patient registration sites, Admissions/Business Office and emergency department within each facility and presented to patients upon request.
2. Each person requesting Financial Assistance must complete a JHM/Financial Assistance application.
3. A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt.
4. Proof of income must be provided with the final application. Acceptable proofs include:
 - (a) Prior year tax return;
 - (b) Current pay stubs;
 - (c) Letter from employer; and
 - (d) A credit bureau report obtained by the JHM affiliates and/or Patient Financial Services Department.
5. An individual will be eligible for Financial Assistance if the maximum family (husband and wife) income (as defined by Medicaid regulations) level does not exceed each affiliates standard related to the Federal poverty guidelines, and they do not own liquid assets which would be available to satisfy their JHHS affiliate bills.
6. All financial resources must be used before the Financial Assistance can be applied. This includes insurance, Medical Assistance, and all other entitlement programs for which the patient may qualify.
7. Financial Assistance is not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary private room accommodations. Non-hospital charges will remain the responsibility of the patient. In the event a question arises as to whether an admission is "elective" or "necessary," the patient's admitting physician shall be consulted. Questions as to necessity may be directed to the physician advisor appointed by the Hospital.
8. Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days (or their specifically established timeline) of satisfactory completion and return of the application. The Manager or designated responsible party will issue the final eligibility determination.
9. Documentation of the final eligibility determination will be made on all (open-balance) patient's account. A determination notice will be sent to the patient.
10. A determination of eligibility for Financial Assistance will remain valid for a period of three (3) months for all necessary JHM affiliate services provided based on the initial date of the determination letter. For recurring outpatient therapeutic services (such as chemotherapy or radiation therapy), patients may qualify for Financial Assistance for up to six (6) months on the basis of a single application. Patients will not be required to reapply for Financial Assistance if they are currently receiving Financial Assistance from another affiliate.
11. All determinations of eligibility for Financial Assistance shall be solely at the discretion of the JHHS affiliate.

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APPENDIX B CATASTROPHIC FINANCIAL ASSISTANCE GUIDELINES

Purpose

These guidelines are to provide a separate, supplemental determination of Financial Assistance for patients who are not eligible for Financial Assistance under the primary section of this policy, but for whom the resulting financial liability for medical treatment represents a catastrophic loss. The patient/guarantor can request that such a determination be made by submitting a JHHS Catastrophic Assistance Application. Under these circumstances, the term "catastrophic" is defined as a situation in which the self-pay portion of the JHM affiliate medical bill is greater than the patient/guarantor's ability to repay with current income and liquid assets in 18 months or less.


General Conditions for Catastrophic Assistance Application:

1. Patient has exhausted all insurance coverage.
2. Patient is not eligible for any of the following:
 - Medical Assistance
 - The JHM Financial Assistance Program.
 - Other forms of assistance available through JHM affiliates.
3. The patient cannot repay the self-responsible portion of the JHHS affiliate account in 18 months or less.
4. The affiliate has the right to request patient to file updated supporting documentation.
5. The maximum time period allowed for paying the non-charitable amount is three (3) years.
6. If a federally qualified Medicaid patient required a treatment that is not approved by Medicaid but may be eligible for coverage by the catastrophic assistance program, the patient is still required to file a JHHS Catastrophic Assistance Application and non-duplicated supporting documentation.

Factors for Consideration

The following factors will be considered in evaluating a Catastrophic Assistance Application:

- Current Medical Debt
- Liquid Assets (leaving a residual of \$2,500)
- Living Expenses
- Projected Medical Expenses
- Annual Income
- Spell of Illness
- Supporting Documentation

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Definitions


Current Medical Debt	Self-responsible portion of current inpatient and outpatient affiliate account(s). Depending on circumstances, accounts related to the same spell of illness may be combined for evaluation. Collection agency accounts are considered.
Liquid Assets	Cash/Bank Accounts, Certificates of Deposit, bonds, stocks, Cash Value life insurance policies, pension benefits.
Living Expenses	Per person allowance based on the Federal Poverty Guidelines times a factor of 3. Allowance will be updated annually when guidelines are published in the Federal Register.
Projected Medical Expenses	Patient's significant, ongoing annual medical expenses, which are reasonably estimated, to remain as not covered by insurance carriers (i.e. drugs, co-pays, deductibles and durable medical equipment.)
Take Home Pay	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, net rental income before depreciation, retirement/pension income, social security benefits, and other income as defined by the Internal Revenue Service, after taxes and other deductions.
Spell of Illness	Medical encounters/admissions for treatment of condition, disease, or illness in the same diagnosis-related group or closely related diagnostic-related group (DRG) occurring within a 120-day period.
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, social security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments; and, credit bureau reports.

Exceptions

1. Each affiliate has the right to refuse treatment for elective procedures, which may result in catastrophic medical debt.
2. The Director of Patient Financial Services (or affiliate equivalent) may make exceptions, as circumstances deem necessary.

Evaluation Method and Process

1. The Financial Counselor will review the Catastrophic Assistance Application and collateral documentation submitted by the patient/responsible party.
2. The Financial Counselor will then complete a Catastrophic Assistance Worksheet (see below) to determine eligibility for special consideration under this program. The notification and approval process will use the same procedures described in the Financial Assistance Program section of this policy.

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Note: If the below worksheet is electronically available to preparer, double-click on worksheet and fill in required amounts in **highlighted fields** only. The worksheet will automatically compute rest of the fields.

FINANCIAL ASSISTANCE WORKSHEET

Patient Name: _____
 History #: _____

LINE #	PARTICULAR	AMOUNT
Net Current Medical Debt:		
1	Current Medical Debt	\$ -
2	Total Liquid Assets	\$ -
3	Asset Exclusion (Fixed Amount)	\$ 2,500
4	Net Liquid Assets [If Line 2 > Line 3, then Line 2 - Line 3, otherwise amount is zero "0"]	\$ -
5	Net Current Medical Debt [Line 1 - Line 4]	\$ -

Total Annual Expenses:		
6	Living Expenses	\$ -
7	Projected Medical Expenses	\$ -
8	Total Annual Expenses [Line 6 + Line 7]	\$ -

Annual Income Available:		
9	Income (Net Take Home Pay)	\$ -
10	% Income Available [100% - (Line 8 divided by Line 9 x 100)] [If Line 8 is > Line 9, then % Income Available is zero "0"]	-%
11	Annual Income Available [Line 9 x Line 10]	\$ -

SELECT PATIENT PAYMENT PERIOD PLAN

Patient Payment in 1-Year Period Plan:		
12	Income Available in 1 Year [Line 11]	\$ -
13	Income Available in 1 Year plus Net Liquid Assets [Line 12 + Line 4]	\$ -
14	Monthly Patient Installment Payment within 1 Year [Line 13 / 12 Months]	\$ -
15	Financial Assistance Amount [If Line 1 > Line 13, then Line 1 - Line 13. This is the Financial Assistance Amount] [If Line 1 < Line 13, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 2-Year Period Plan:		
16	Income Available in 2 Years [Line 11 x 2 Years]	\$ -
17	Income Available in 2 Years plus Net Liquid Assets [Line 16 + Line 4]	\$ -
18	Monthly Patient Installment Payment within 2 Years [Line 17 / 24 Months]	\$ -
19	Financial Assistance Amount [If Line 1 > Line 17, then Line 1 - Line 17. This is the Financial Assistance Amount] [If Line 1 < Line 17, then the Financial Assistance Amount is zero "0"]	\$ -

Patient Payment in 3-Year Period Plan:		
20	Income Available in 3 Years [Line 11 x 3 Years]	\$ -
21	Income Available in 3 Years plus Net Liquid Assets [Line 20 + Line 4]	\$ -
22	Monthly Patient Installment Payment within 3 Years [Line 21 / 36 Months]	\$ -
23	Financial Assistance Amount [If Line 1 > Line 21, then Line 1 - Line 21. This is the Financial Assistance Amount] [If Line 1 < Line 21, then the Financial Assistance Amount is zero "0"]	\$ -



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**TABLE FOR DETERMINATION OF
FINANCIAL ASSISTANCE ALLOWANCES**

Effective 2/1/08

# of Persons in Family	Income Level	Upper Limits of Income for Allowance Range				
1	\$ 15,600	\$ 18,720	\$ 20,280	\$ 23,400	\$ 24,960	\$ 28,080
2	\$ 21,000	\$ 25,200	\$ 27,300	\$ 31,500	\$ 33,600	\$ 37,800
3	\$ 26,400	\$ 31,680	\$ 34,320	\$ 39,600	\$ 42,240	\$ 47,520
4	\$ 31,800	\$ 38,160	\$ 41,340	\$ 47,700	\$ 50,880	\$ 57,240
5	\$ 37,200	\$ 44,640	\$ 48,360	\$ 55,800	\$ 59,520	\$ 66,960
6	\$ 42,600	\$ 51,120	\$ 55,380	\$ 63,900	\$ 68,160	\$ 76,680
7	\$ 48,000	\$ 57,600	\$ 62,400	\$ 72,000	\$ 76,800	\$ 86,400
8*	\$ 53,400	\$ 64,080	\$ 69,420	\$ 80,100	\$ 85,440	\$ 96,120
Allowance to Give:	100%	80%	70%	50%	40%	20%

EXAMPLE: Annual Family Income \$48,000
 # of Persons in Family 4
 Applicable Poverty Income Level \$31,800
 Upper Limits of Income for Allowance Range \$57,240 (20% range)
 \$48,000 is less than the upper limit of income; therefore patient is eligible for financial assistance.

*For family units with more than eight (8) members, add \$5,400 for each additional member.

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Other property		Approximate value _____
Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No
 For what service? _____
 If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

Applicant signature

Date

Relationship to Patient

Exhibit A

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals.

	Monthly Amount
Employment	_____
Retirement/pension benefits	_____
Social security benefits	_____
Public assistance benefits	_____
Disability benefits	_____
Unemployment benefits	_____
Veterans benefits	_____
Alimony	_____
Rental property income	_____
Strike benefits	_____
Military allotment	_____
Farm or self employment	_____
Other income source	_____
Total	_____

II. Liquid Assets

	Current Balance
Checking account	_____
Savings account	_____
Stocks, bonds, CD, or money market	_____
Other accounts	_____
Total	_____

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home	Loan Balance _____	Approximate value _____
Automobile	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Additional vehicle	Make _____ Year _____	Approximate value _____
Other property		Approximate value _____
Total		_____

IV. Monthly Expenses

	Amount
Rent or Mortgage	_____
Utilities	_____
Car payment(s)	_____
Credit card(s)	_____
Car insurance	_____
Health insurance	_____
Other medical expenses	_____
Other expenses	_____
Total	_____

Do you have any other unpaid medical bills? Yes No
 For what service? _____
 If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

Applicant signature

Date

Relationship to Patient