Financial Hardship

It is the policy of the Practice that patients experiencing financial hardship may apply for a discount or waiver of the patient's financial responsibility (e.g., copayment, coinsurance, and/or deductible). Whether or not such a discount or waiver is granted shall be based on an individual assessment of the patient's financial circumstances, and an assessment of the Practice's legal and contractual obligations to the third-party payers.

Before a discount or waiver is offered to the patient a payment plan will be discussed as the first option. A minimum monthly payment of $25 is required.

Patients' will be reminded that they have a financial obligation to cover any co-payments or deductibles based on the insurance they have purchased and that the Practice has a legal obligation to collect those payments based on the contracts that are signed.

PROCEDURES

1. The Practice does not advertise its financial hardship discount program, nor does it routinely offer discounts or waivers to patients.

2. The Practice determines whether the patient is a beneficiary of a private third-party payer plan. If appropriate, the Practice determines whether its agreement with the payer prohibits a financial hardship waiver or discount.

3. In order to be considered for a discretionary discount or waiver, individualized documentation of financial hardship must be included in the patient's medical record and a supporting note in the patient's financial account. The documentation needed to apply for a financial hardship discount or waiver is listed below:

    a. A completed Patient Financial Assessment Form (see below). Hart Associates will send the form to the patient (instructions on form are to send completed documents to Cindy Donoghue at NEOGA).

    b. One or more of the following:

        1) Documented proof that a patient is at or below 200 % federal poverty guidelines (free care) or 400 % (partial free care) published annually by the U.S. Department of Health and Human Services. Documented proof may include documents such as W-2 withholding statements, unemployment check stubs, pay check stubs, income tax return (1040), forms from Medicaid or other State-funded medical assistance, forms from employers, and/or welfare or community agencies; or
        2) Documentation that a patient has other circumstances that indicate financial hardship, which may include, but not be limited to, proof of bankruptcy settlement, catastrophic situations (for example, death or disability in family) or another documentation that shows that patient would be unable to pay medical bill and still be able to pay for other

basic necessary expenses. The Practice Administrator or designee will be responsible for considering the grant or denial of hardship status under these circumstances on a case-by-case basis. Documentation must be submitted for the review.

c. Income shall be annualized from the date of request based on the documentation provided and upon verbal information provided by the patient. The annualization will also take into consideration seasonal employment and temporary increases and/or decreases to income.

4. Discounts or waivers for Medicare beneficiaries shall be applied only to the coinsurance or deductible amounts owed by the patient. Discounts for Medicaid beneficiaries shall be determined in accordance with applicable state law.

5. Any denial of the financial hardship discount or waiver request is documented and includes instructions for reconsideration. If additional documentation is received to support the financial hardship, the request will be reviewed and considered per the above guidelines. The decision of the Administrator or designee is final.

6. All information relating to financial hardship requests will be kept confidential, except insofar as required by law.

PATIENT FINANCIAL ASSESSMENT FORM

Date: _____ Account #: _____

Social Security #: _____

Patient Last Name: _____ First Name: _____

Address: _____City: _____ State: ____ ZIP Code: _____

Phone: _____ Alternate Phone: _____

Name of responsible party (if not patient, print name of Guarantor): _____

Patient Employer: _____ Employer Phone: _____

Employer Address: _____City: _____ State: ___ ZIP Code: _____

Length of Employment: _____If unemployed, last date of employment: _____

Spouse Last Name: _____ First Name: _____

Spouse Employer: _____ Employer Phone: _____

Employer Address: _____City: _____ State: ___ ZIP Code: _____

Length of Employment: _____If unemployed, last date of employment: _____

Total in household (include yourself): Adults (18+) _____ Minors (under 18) _____

Guarantor (responsible party) Employer: _____ Phone: _____

Employer Address: _____City: _____ State: ___ ZIP Code: _____

Length of Employment: _____If unemployed, last date of employment: _____

Income (monthly)	Patient	Spouse	Responsible Party (Whom)	Children Working
Gross Monthly Salary	$	$	$	$

Public Assistance Benefits	$	$	$	$
Unemployment Benefits	$	$	$	$
Social Security Benefits	$	$	$	$
Workers' Compensation	$	$	$	$
Child Support	$	$	$	$
Other (Alimony, Pension, Life Insurance, VA Benefits, Disability)	$	$	$	$

Totals: $_____ $_____ $_____ $_____

Total Family Income: *$*_____

Other Assistance: _____

Have you applied for Medicaid: Yes No (circle)

If 'yes,' provide current status or attach denial letter: _____

Have you tried to obtain financial assistance from other organizations? Yes No (circle)

List the organizations and current status:

_____

_____

List all outstanding hospital/physician bills:

1. _____
2. _____
3. _____
4. _____
5. _____

Please provide any additional information/comments:
(attach additional sheet if more space is required, or use back of this form.)

_____

_____

Financial Documentation: (attach copies)

Previous year 1040 IRS: $_____ Year _____

W-2s: $_____ Year _____

If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.	Other (unemployment, Social Security, disability and workers' compensation): (attach copies)
$ _____ Date _____	$_____
$ _____ Date _____	$_____
$ _____ Date _____	
$ _____ Date _____	

	Monthly Payment
Mortgage/Rent	$
Gas & Electric	$
Telephone	$
Car Insurance	$
Car Payment	$
Food	$
Total Monthly Expenses This Column	$
Total Monthly Expenses Other Column	$
Monthly Expense Grand Total	$
Yearly Household Income	
Gross:	$
Net:	$

	Credit Limit	**Balance**	**Monthly Payment**
VISA	$_____	$_____	$_____
MC	$_____	$_____	$_____
AMEX	$_____	$_____	$_____
Discover	$_____	$_____	$_____

Other Expenses (Provide Explanation)

_____ $_____

_____ $_____

_____ $_____

Total $_____

* *I declare that I have examined this application and to the best of my knowledge all information in it or otherwise provided to NEOGA are true, correct, and complete. I understand that misrepresentation of this information may cancel any financial assistance I may be provided and that I will then be liable for all medical charges.*

* *By signing and submitting this request, I give NEOGA permission to determine my need for financial assistance; including review of my credit file. I also give permission to NEOGA to release or disclose this information to NEOGA for the purpose of evaluating my financial status in response for assistance with my hospital bills.*

* *I understand that it is my responsibility to advise NEOGA of any changes in status in regards to my income or assets while this application is in process.*

Signature of Patient: _____ Date:_____

Signature of Spouse or Guarantor: _____ Date:_____

Return this form and supporting documentation within 30 days to the ***Lauren O'Brien 200 Boylston St Suite 301 Chestnut Hill, MA 02467****. If you have questions, you may call 617-731-3400 ext. 157*

FOR OFFICE USE ONLY

Total wages for calendar year: $ _____

Check when completed:

Total Household: $ _____

Added to practice management system ❑

Eligible Discount: $ _____

Date Completed:_____ By: _____

Notes: _____ Name/Phone: _____

_____