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: _________________

<table>
<thead>
<tr>
<th>Income (monthly)</th>
<th>Patient</th>
<th>Spouse</th>
<th>Responsible Party (Whom)</th>
<th>Children Working</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Monthly Salary</td>
<td>$</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

Financial Hardship 6-2018

Patients Rights

| 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 _________________

Financial Hardship 6-2018
If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.

<table>
<thead>
<tr>
<th>Income</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$________________</td>
<td>Date ______________</td>
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<tr>
<td>$________________</td>
<td>Date ______________</td>
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<td>$________________</td>
<td>Date ______________</td>
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<tr>
<td>$________________</td>
<td>Date ______________</td>
</tr>
</tbody>
</table>

Other (unemployment, Social Security, disability and workers’ compensation): (attach copies)

<table>
<thead>
<tr>
<th>Income</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$________________</td>
<td>Date ______________</td>
</tr>
<tr>
<td>$________________</td>
<td>Date ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly Payment</th>
<th>Credit Limit</th>
<th>Balance</th>
<th>Monthly Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage/Rent</td>
<td>$________</td>
<td>$______</td>
<td>$________</td>
</tr>
<tr>
<td>Gas &amp; Electric</td>
<td>$________</td>
<td>$______</td>
<td>$________</td>
</tr>
<tr>
<td>Telephone</td>
<td>$________</td>
<td>$______</td>
<td>$________</td>
</tr>
<tr>
<td>Car Insurance</td>
<td>$________</td>
<td>$______</td>
<td>$________</td>
</tr>
<tr>
<td>Car Payment</td>
<td>$________</td>
<td>$______</td>
<td>$________</td>
</tr>
<tr>
<td>Food</td>
<td>$________</td>
<td>$______</td>
<td>$________</td>
</tr>
</tbody>
</table>

Other Expenses (Provide Explanation)

**Yearly Household Income**

<table>
<thead>
<tr>
<th>Gross: $</th>
<th>Net: $</th>
</tr>
</thead>
<tbody>
<tr>
<td>$______________</td>
<td>$________</td>
</tr>
</tbody>
</table>

Financial Hardship 6-2018
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: ________________________

______________________________________________