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**ADMINISTRATIVE MANUAL**  
**FINANCIAL ASSISTANCE A-090**

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- POLICY:** Healthsource Saginaw will grant financial assistance to patients/residents who cannot pay for services rendered due to financial hardship. The allowance calculation is based upon the annually published Federal Register's income and poverty guidelines. HealthSource Saginaw will use a sliding fee schedule to determine if discounting would be appropriate.
- PURPOSE:** To establish procedures for allowance of financial assistance as recommended by Federal recommendations.
- PROCEDURE:**
1. When the Patient Financial Representative is notified that a patient/resident may qualify for financial assistance, an Application for Financial Assistance Determination Form (PA-27 attached) is mailed out for completion.
  2. When the form is completed, the application and patient/resident file is referred to the Chief Financial Officer or designee for review and determination. The decision will be based on the charity guidelines and the information reported on the Application for Financial Assistance Determination Form (PA-27).
  3. Property value, savings account balances, and checking account balances will be added to income based on the following:
    - a. Property value in excess of twice the poverty level will be added to income.
    - b. Savings account and checking account balances in excess of one time the poverty level will be added to income.
  4. Applicants at or below the government guidelines are eligible for approval of financial assistance considerations. When a patient or resident qualifies for a financial assistance allowance, Adjustment Form (PA-26) will be completed for the amount to be adjusted. The Chief Financial Officer will review all financial assistance applications and determine actions and recommend approval of financial assistance allowances to the President & CEO.
  5. The patient/resident/guarantor will be notified by the Patient Financial Representative of the final decision made whether the costs of care is considered financial assistance or a portion of the balance owing will be considered financial assistance.

6. Patients who have qualified for Public Assistance and have been determined to have a patient pay amount will not qualify for further Financial Assistance through HealthSource Saginaw. These patients have already been granted assistance by the government.

7. Policy A-90 is not applicable to Private Pay Extended Care residents in the Long Term Care neighborhoods; these residents receive applicable discounts under Policy a-122.

8. Financial Assistance approvals will be honored for six months from the original date of service with an open balance. Further consideration would require additional application and proof of income.

#### Financial Assistance Policy

REVISED: July 2001, February 2009, June 2009, February 2014, February 2017

REVIEWED: December 2004, March 2011, October 2016

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Lisa Lapham  
President & CEO

Attachments: PA-27 – Financial Assistance Determination Form (Appendix II)

**HEALTHSOURCE SAGINAW, INC.**  
**PATIENT FINANCIAL PROFILE**

The information requested on this form is to provide HealthSource Saginaw the ability to give full consideration to a request for credit through an extended payment agreement or financial assistance. This information will be kept confidential and will not be used for any other purpose. By signing below, you attest to the fact that all is true and correct.

**PATIENT INFORMATION**

**DATE:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Social Security Number: \_\_\_\_\_

Telephone Number: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Guarantor Name: \_\_\_\_\_

Guarantor Address: \_\_\_\_\_  
\_\_\_\_\_

Guarantor Social Security Number: \_\_\_\_\_

Guarantor's Telephone: Home: \_\_\_\_\_

Work: \_\_\_\_\_

Cell: \_\_\_\_\_

Number of dependents w/ages: \_\_\_\_\_

Guarantor's Employer: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Spouse's Full Name: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_ Years Employed: \_\_\_\_\_

Has patient applied for health coverage via the Affordable Care Act? Y / N

Date: \_\_\_\_\_ Please attach copy of response

## INCOME INFORMATION

Gross Wages: Guarantor: \$ \_\_\_\_\_ (weekly, bi-weekly, annually)

Spouse: \$ \_\_\_\_\_ (weekly, bi-weekly, annually)

Other Income: \$ \_\_\_\_\_ (Social Security, Pension, Child Support, SSI, Investments, Alimony, etc.)

## ASSET INFORMATION

Housing: Rent: \_\_\_\_\_ Own: \_\_\_\_\_ -If owned, indicate value of home: \$ \_\_\_\_\_

Automobiles:

1) Year \_\_\_\_\_ Make \_\_\_\_\_ Value: \$ \_\_\_\_\_

2) Year \_\_\_\_\_ Make \_\_\_\_\_ Value: \$ \_\_\_\_\_

3) Year \_\_\_\_\_ Make \_\_\_\_\_ Value: \$ \_\_\_\_\_

Checking Account(s) Current Balance: \$ \_\_\_\_\_

Bank/Institution(s): \_\_\_\_\_

Savings Account(s) Current Balance: \$ \_\_\_\_\_

Bank/Institution(s): \_\_\_\_\_

Other Assets (Please list item and value) (i.e.: boat, vacation homes, time shares, etc.)

**STATEMENT:**

The information provided on this form is subject to verification. Please attach copies of your most recent pay stubs (one month), three months of bank statements, your last Federal Income tax forms to support the information provided on this document. This form MUST be filled out in its entirety and include the requested documents in order to be considered.

Printed Name of person completing this form: \_\_\_\_\_

Telephone # for questions: \_\_\_\_\_

Relationship to the patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of person completing this form

\_\_\_\_\_  
Date

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**FOR INTERNAL USE ONLY:**

Approved

Denied

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

Reason for denial:

## 2017 Federal Poverty Guidelines

Household Size	100%	150%	200%	250%	Household Size	100%
1	\$12,060	\$18,090	\$24,120	\$30,150	1	\$12,060
2	\$16,240	\$24,360	32,480	\$40,600	2	\$16,240
3	\$20,420	\$30,630	40,840	\$51,050	3	\$20,420
4	\$24,600	\$36,900	49,200	\$61,500	4	\$24,600
5	\$28,780	\$43,170	57,560	\$71,950	5	\$28,780
6	\$32,960	\$49,440	65,920	\$82,400	6	\$32,960
7	\$37,140	\$55,710	74,280	\$92,850	7	\$37,140
8	\$41,320	\$61,980	82,640	\$103,300	8	\$41,320
DISCOUNT	75%	50%	25%	10%	DISCOUNT	75%

FOR FAMILY UNITS OF MORE THAN 8 MEMBERS, ADD \$4,160 FOR EACH ADDITIONAL MEMBER