ADMINISTRATIVE MANUAL
FINANCIAL ASSISTANCE A-090

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

____

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

____

FOR INTERNAL USE ONLY:

☐ Approved ☐ Denied

____ _________________________

Authorized Signature Date

Reason for denial:

2021 Income Poverty Guidelines Chart

2021 Income Poverty Guidelines (200%)			
Family Size	**Annual**	**Monthly**	**Weekly**
1	$25,760	$2,147	$495
2	$34,840	$2,903	$670
3	$43,920	$3,660	$845
4	$53,000	$4,417	$1,019
5	$62,080	$5,173	$1,194
6	$71,160	$5,930	$1,368
7	$80,240	$6,687	$1,543
8	$89,320	$7,443	$1,718
Each Add'l Person	$9,080	$757	$175