SCHC

Sheridan County Health Complex

FINANCIAL ASSISTANCE WORKSHEET

NOTE: only fill in areas colored in this shade

Patient Name: _____ Guarantor Name: _____

Account to be considered for write off:

Account #	Balance	Status	Agency	Insurance
	$ -			
	-			
	-			
	-			
	-			
	-			
	-			
	-			
	-			
	-			
TOTAL	-			

Family Size: _____ Annual Income: _____

Eligibility Calculation:

Step One:

Annual Income $ -

divided by #N/A (FPG)

equals #N/A (FPG Rate)

2019 Poverty Income Guidelines 100%	
Size of Family	Fed Proverty Guideline (FPG)
1	$ 12,490
2	16,910
3	21,330
4	25,750
5	30,170
6	34,590
7	39,010
8	43,430
Note: add $432.00 for each additional family member per month	

Step Two:

FPG Rate	% of Sponsored Care Allowed	Calculated Rate
Rate <= 1.5	80%	#N/A
1.5 < Rate <= 2.0	40%	#N/A
2.0 < Rate <= 2.5	15%	#N/A
2.5 < Rate	0%	#N/A

Step Three:

Sponsored Care Calculation

Insurance Type	Amount Owed	% Allowed	Write off AMT
Pending Insurance	$ -	#N/A	#N/A
Bad Debt	-	#N/A	
Self Pay	-	#N/A	#N/A

Comments: _____

Prepared By: _____

CFO: _____ Date: _____

RC: _____ Date: _____

Date: _____

Application for Financial Assistance Program

Please fill out the attached "*Personal Statement for Financial Assistance*" for.

Copies of the following items must accompany the application:

1. Copy of all earning statements (pay stubs) for the last 3 months
2. Copy of all banking and savings accounts statements for the last 3 months
3. Copy of your most recent Income Tax returns.
4. "Personal Financial Statement" form

Applicants Signature _____ Date _____

Please return application and documentation to:

Peggy Ritter

Sheridan County Hospital

P O Box 167

Hoxie, KS 67740

Personal Financial Statement for Financial Assistance

Patient Name	Age	Phone Number	Marital Status S M W D	Social Security Number

Date Pt. Received:	Acct. # / Balance: / $	; Acct. # / Balance: / $
Please Return By:	Acct. # / Balance: / $	; Acct. # / Balance: / $
Date Returned:	Acct. # / Balance: / $	; Acct. # / Balance: / $

Patient		Person Responsible for Bill (if not patient)	Relationship
Street:		Name:	
		Street	
City, ST, Zip		City, ST Zip	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, Name of Last Employer:	If unemployed, Name of Last Employer:
How Long Unemployed?	How Long Unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes_____ No_____

If yes, why not available for this date of service? _____

If no, please indicate the reason for lack of insurance coverage? Insurance cost too high? Yes_____ No_____;
Pre-existing condition? Yes_____ No_____; Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date: _____ Reason for Denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income			
	Patient	Spouse	Other Members of Household (18 and older)
Wages (Gross)	$	$	
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List			
MONTHLY INCOME SUBTOTAL			
TOTAL INCOME:	**MONTHLY: $**		**YEARLY: $**

EXPENSES	MONTHLY	BALANCE DUE
Mortgage or Rent Payment	$	$
Car Payment		
Utilities (Gas, Electric, Water		
Cable		
Phone (Including Cell)		
Food		
Child Care		
Clothing		
Insurance (Auto, Life, Health)		
Gas/Transportation		
Recreation		
Physicians		
Hospitals		
Other Medical		
Credit Cards		
Other Expenses (Describe)		
TOTAL EXPENSES:	$	$

HOUSEHOLD ASSETS	VALUE
Savings	$
Checking	
Stocks and Bonds	
Mutual Funds, Money Marekt, etc.	
Cash Value of Life Insurance	
Real Estate Value	
Farming Real Estate Value	
Vehicles Value (not primary)	
Jewelry & Other Personal Property	
Other Assets (Describe)	
TOTAL HOUSEHOLD ASSETS:	$

HOUSEHOLD DEBTS	VALUE
Home Loan	$
Auto Loan	
Credit Card Debt	
Other: Total Expenses from "Balance Due"	
column - (Mortgage + Car Loan + Cr, Cards)	
TOTAL HOUSEHOLD DEBTS:	$

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date:

Application Determination: Approved / Denied Date Determination Letter Mailed: _____

Reason for Denial: _____

Hospital Representative Signature(s) Date:

SHERIDAN COUNTY HEALTH COMPLEX Payment Policy

Una versiòn en Española de este Programa de Asistencia Financiera y Politica de pago està disponible en la Oficina de Negocios bajo peticiòn.

All open accounts at Sheridan County Health Complex (SCHC) are due within 30 days of the time of the first billing. Payment arrangements can be made by contacting the Business Office. Payment arrangements and or installment payments will be allowed under the following provisions.

Account balances can be reduced using equal installment payments based on the following guidelines.

- Balances of $600.00 or less are to be paid in full within 6 months. (minimum of $50)
- Balances of $600.01 - $1500.00 are to be paid in full within 12 months.
- Balances of $1500.01 - $5000.00 and higher are to be paid in full within 18 months.

Payment arrangements must be made within 60 days of the initial billing for services provided by SCHC. The account may be turned over to a servicing agency if no payment is received within 120 days of initial bill. If payment arrangements have been made and two payments in a 12 month period are missed, the account will be turned over to a servicing agency if not brought current within 15 days.

Electronic Funds Transfer (EFT) payments can be established by contacting the Business Office. Minimum payment will be $50.00 per month. A $30.00 fee for any returned check or rejected EFT will be assessed to the patient's account and will be subject to collections if no other arrangements are made. **You may receive a separate bill from Hoxie Medical Clinic for those questions please call 785-675-3018.** A drop box has been installed by hospital registration door for both hospital and clinic drop off payments.

If you are uninsured, or if your insurance company will not prior authorize the services you are receiving, 50% of the cost is due at the time services are rendered.

Upon request, a cash discount is available on balance of $500 or more. It is due before first statement due date. Please call for information (785)675-3281.

Financial Assistance Program (FAP)

If a patient cannot make the payments outlined above, they must contact the Community Resources department at 785-677-4172 and fill out a FAP Application. Upon verification of the patient's income, they may qualify for a reduced bill and discount based on Federal Poverty Guidelines. Payments less than $50.00 per month will only be accepted if patient has begun the FAP Application process, and must be completed within 60 days.

Consistent with the federal law, SCHC and HMC do not discriminate on the basis of age, gender, race, ethnic status or ability to pay in the provision of emergency medical conditions or credit services.

REVISED BOT APPROVED 07.29.2019

FINANCIAL ASSISTANCE PROGRAM

Sheridan County Hospital (SCHC) offers financial assistance to patients who qualify under the Federal Poverty level guidelines.

A Copy of our Financial Assistance Policy and the application to apply can be found as follows:

- On our website: www.sheridancountyhospital.com
- In person at our business office
- Request by phone at 785-677-4172
- Request by mail at SCHC FAP APP P O Box 167 Hoxie, KS 67740

La solicitud para asistencia financier en en relicio a sus cuentas medicas con Sheridan County Hosptial esta disponible en Espanol.

(The Financial Assistance Policy and application are available in Spanish.)

If you are eligible for financial assistance, you will not be charged more than amount generally billed to insured patients. You could qualify for up to an 80% reduction of charges.

Consistent with the federal law, SCHC does not discriminate on the basis of age, gender, race, ethnic status or ability to pay in the provision of emergency medical conditions or credit services.

Financial Assistance Program Packet

Included in this packet is:

A Financial Assistance Program application that includes Personal Financial Statements: please fill out the best you can. Anything that does not apply to you please write **N/A** on the line instead of leaving it blank. You must return this packet within two weeks. Please do not wait until you gather all your information. A file will be started for you and you can drop off copies of needed information at any time. Also included in this packet is the Sheridan County Health Complex Payment Policy. If after going over the application you are uncertain how to fill this out, call us and an appointment can be set up to help you with this.

If you do not have earning statements, bank statements, or you have not file taxes please talk to **Peggy Ritter, 785-677-4172 or Becky Mullins, 785-677-4114** and they will advise you on what is needed in place of these items.

Thank you for your cooperation,

Sheridan County Health Complex

Checklist for Medicaid Application

1. Driver's license/or ID card
2. Social Security card
3. Insurance Card/Medicare card/ Any secondary ins. Cards
4. Birth certificate
5. Last 3 months of bank statements-start the month you are in and go back 3 months. Will actually end up with 4 months worth.
6. If you own a home/tax appraisal. If home isn't paid off/mortgage agreement/amount paid on and amount owed.
7. Title of vehicle
8. House and vehicle insurance-information and copies of policies
9. Social security benefit statement
10. Life insurance polices/ copy of policy-face value and cash pay out
11. Funeral and burial plan information/call funeral home for verification
12. Savings account/,CD's/IRA's/stocks and bonds-last 3 months
13. Land/boats-any other assets/need all the information you have
14. All medical and drug bills for last 3 months. Even paid ones.
15. Nursing home bill or statement
16. Advance Directives