POLICY:

Procedures are in place to provide services on a free or partial pay basis to Medicaid eligible or financially indigent patients.

PURPOSE:

To assist patients in receiving services if they meet the financial requirements of Medicaid eligible or financially indigent.

PROCEDURE:

When a Medicaid eligible or financially indigent patient requests their account be considered as a charity write-off, the patient is required to complete a FINANCIAL ASSISTANCE FORM.

1. It will be requested of the patient to provide a copy of the previous years Federal Income Tax Statement, W-2, Medicaid eligibility cards, or current payroll stub.
2. Upon receipt of the FINANCIAL ASSISTANCE FORM, the National Poverty Level Sliding Scale will be reviewed to determine where the patient's income resides.
3. If the patient meets or is below the gross income amount of the national poverty level, the appropriate write-off is made applicable to the procedure charge amount.
4. If the patient does not meet the gross income amount of the national poverty level, a sliding scale is reviewed to determine where the patient's income resides, and if a write-off is applicable.
5. The FINANCIAL ASSISTANCE FORM will be kept in the medical chart, and copies provided to the patient as well as the Business Office.

When a MEDICAID eligible patient is seen at the Center, copies of their Medicaid card will be obtained.

1. One copy will be kept in the medical chart and one copy provided to the Business Office.
2. The Business Office will file with Medicaid on behalf of the patient.

The Business Operations representative is responsible for management and oversight of the application of the financial hardship discount for Medicaid eligible patients.

	Financial Assistance Form		
Monthly Income: Please indicate all sources of income			
	Source		**Amount**
Patient:			$
Spouse:			$
Other:			$
Number of dependents			
	Total Monthly Income:		
		Gross:	$
		Net:	$
Monthly Expenses: Please indicate average expenses			
Rent /Mortgage:	$	Utilities:	$
Auto 1:	$	Telephone:	$
Auto 2:	$	Child Care:	$
Auto Insurance:	$	Groceries:	$
Health Insurance:	$	Medications:	$
Credit Cards (list)		Physicians (list)	$
Visa	$		$
MasterCard	$		$
Discover	$		$
Department Store	$		$
Other Credit Card	$	Other (list)	$
Other Credit Card	$		$
	Total Expenses $		
Total Monthly Income: $			
Total Monthly Expenses: $			
Total Monthly Income minus Expenses: (Grand Total): $			
I certify the above information is correct and that payment of my liability would present a financial hardship.			
Signature of patient or guardian			