



**Hospital Policy Manual
Patient Accounts Section**

Subject:	Financial Assistance Policy
Originator:	Director, Revenue Cycle
Approved By:	Vice President, Finance/CFO
Policy Coordinator:	Vicki Salyer
Scope:	All CHA
Effective:	3/7/90
Revised:	7/31/92, 3/8/94, 3/3/97, 6/15/00, 2/28/01, 5/7/01, 3/12/04, 3/1/05, 3/3/06, 4/27/07, 10/10/08, 4/9/09, 7/1/09, 10/23/10, 5/1/11, 3/2/12, 3/25/13 (Attachment 1 only), 12/31/14, 12/29/15
Reviewed:	N/A
Reference(s):	N/A
Previous Number:	7220.01
Attachment(s):	Attachment A: Information Tables (Page 13) Attachment B: Application for Financial Aid (Pages 14-15) Attachment C: Plain Language Summary (Page 16)

PURPOSE: To ensure policy and procedures exist for identifying those patients for whom service is to be rendered free of charge or at a discount based solely on ability to pay, financial condition and availability of third-party funding. To clearly differentiate those patients eligible for Financial Assistance based on established guidelines from those patients with financial resources who are unwilling to pay.

POLICY STATEMENT:

- A. It is the policy of Community Hospital Anderson (CHA) that anyone who identifies themselves as unable to pay all or part of their medical care maintains the right to apply for financial assistance. A **financial clearance process** will be followed by associates of Community to determine if a patient meets CHA’s definition of a medically indigent patient or may qualify for other forms of financial assistance. Charity is not considered a substitute for personal responsibility. Patients are expected to cooperate with Community’s procedures and fulfill documentation requirements required for qualification for the assistance program. In addition, patients will be expected to contribute to the cost of their care based on their ability to pay. Individuals with the financial capacity to afford insurance will be encouraged to do so in order to ensure access to future healthcare services, protect their overall health, protect their assets and lower the costs of care for the citizens of Madison County.

B. Community Hospital Anderson in keeping with its mission serves the medical needs of the community regardless of race, creed, color, sex, national origin, sexual orientation, handicap, residence, age, ability to pay or any other classification or characteristic. We recognize the need to render care to the sick that do not possess the ability to pay. Medically necessary health care services will be provided to these patients with no expected reimbursement or at a reduced level of reimbursement based upon established criteria, recognizing the need to maintain the dignity of the patient and family during the process. We expect all responsible parties with the ability to pay to meet their financial obligations in a timely and efficient manner, in accordance with our collection policies. The amount of free or discounted care considered will be reviewed and approved without jeopardizing our continued financial viability.

C. Definitions:

- **Amount Generally Billed (AGB):** The amount generally billed to insured patients for emergent or medically necessary care as calculated by reviewing the prior 12 month closed claim reimbursement rate for Medicare and Commercial Insurance. AGB is updated annually.
- **Applicant:** Patient or Guarantor requesting screening for the Financial Assistance Program. This may include an individual or a family (multiple wage earners within the same home) that fulfill the definition of “Family” below.
- **Charity Care:** Medically necessary services that are delivered but are never expected to be fully reimbursed. These services represent the facility’s policy to provide free or discounted care to qualifying members of the service area (referenced in Attachment A).
- **Emergency Care:** Immediate care that is necessary to prevent putting the patient’s health in serious jeopardy, serious impairment to bodily functions and/or serious dysfunction of any organs or body parts.
- **Family:** Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage or adoption. According to the Internal Revenue Service, if the patient claims someone else as a dependent on their income tax return, they may be considered as dependent for the purposes of the provision of financial assistance.
- **Family Income:** Family Income is determined using the Census Bureau definition, which uses the following income when computing Federal Poverty Guidelines: earnings, unemployment compensation, workers’ compensation, social security, supplemental security income, public assistance, veteran’s payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources; non-cash benefits (such as

food stamps and housing subsidies) do not count; determined on a **before** tax basis; excludes capital gains and losses; if a person lives with family, includes the income of all family members (non-relatives, such as housemates, do not count).

- **Gross Charges:** The full amount charged by Community for items and services before any discounts, contractual allowances or deductions are applied.
- **Medically Indigent:** A medically indigent patient is defined as one whose income is sufficient to cover basic living expenses but cannot pay for medical services. The term may also be applied to persons with adequate incomes who are faced with unexpected, catastrophically high medical bills.
- **Medically Necessary:** Hospital services or care rendered both outpatient and inpatient to a patient in order to diagnose, alleviate, correct, cure or prevent the onset or worsening of conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or aggravate a handicap or result in overall illness of infirmity.
- **Presumptive Eligibility:** The process by which Community may use previous eligibility determinations and/or information from sources other than the individual to determine eligibility for financial assistance.
- **Uninsured:** The patient has no level of insurance or other third party assistance to assist with meeting payment obligations for healthcare services.
- **Underinsured:** The patient has some level of health insurance but the out-of-pocket expenses still exceed his/her financial capability.
- **Urgent Care:** Medically necessary care to treat medical conditions that are not immediately life-threatening but could result in the onset of illness or injury, disability, death or serious impairment or dysfunction if not treated within 12-24 hours.
- **Cost of Care:** In cases where discounts or the Financial Assistance Policy may apply, adjustments will be made to total gross charges unless otherwise specified.

D. Program Detail

1.0 Policy Terms

1.1 This section intentionally left blank.

1.2. **Non-discrimination:** We will render services to our patients who are in need of Medically Necessary Services regardless of the ability of the Responsible Party to pay for such services. The determination of full or partial Financial Assistance will be based on the ability to pay and financial condition and will not be based on race, creed, color, sex, national origin, sexual orientation, handicap, residence, age or any other classification or

characteristic. Further, and following a determination of Financial Assistance Program eligibility and in accordance with the Affordable Care Act (ACA), the eligible individual will not be charged more for emergency or other medically necessary services than the amounts generally billed to individuals who have insurance covering such services.

1.3. Available Services: All available medically necessary health care services, inpatient and outpatient, will be available to all individuals under this policy. Specifically, the following healthcare services fall within the scope of the Financial Assistance Program at Community:

- Emergency Medical Services provided in an Emergency department setting at any Community Health Network hospital (RC 450,451)
- Services delivered in any setting that if delayed would result in an adverse change in the health status of a patient
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting

1.4. Program Exclusions:

1.4.1. All services provided to a patient that are deemed elective or not medically necessary will not be subject to any financial assistance discounting. This would include but is not limited to the following service types:

- Cosmetic procedures (plastics)
- Bariatric procedures
- Infertility Services
- Certain orthopedic procedures
- Genetic testing that is not used for treatment
- Procedures or testing that are not covered by Medicare may be excluded

1.4.2. Charity Care is not considered a substitute for personal responsibility and patient or guarantor will be expected to contribute to the cost of care based upon the ability to pay. For this reason, the following will be excluded from provision of charity coverage:

1.4.2.1 Coverage under the Community program will only be provided to citizens of the United States or legally documented aliens and applicants may be asked to provide documentation related to their citizenship or legal status. Exceptions are made for emergency services.

1.4.2.2 Coverage will exclude applicants residing outside of Community's primary service area of Indiana.

1.4.2.3 Intentionally left blank

1.4.2.4 Patients making less than 100% of the Federal Poverty Level, meeting all other policy requirements and who have cooperated with attempts to obtain health insurance will be granted 100% charity write-off.

- Patients with income between 101-200% FPL will

have a patient responsibility portion of \$25 for each outpatient account and \$50 for each Emergency Room observation or inpatient visit.

- Patients with income between 201% and 300% of the federal poverty income guidelines may be eligible for patient sliding scale hardship as laid out in Attachment C.

1.4.2.5 Coverage exceptions may be made in the case of financial hardships due to excessive medication costs, extensive hospitalizations or other extenuating circumstances. Determination of coverage of these special circumstances will be reviewed on a case-by-case basis. Exceptions will be made when total medical debt meets or exceeds 25% of the annual household income.

2.0 Determination of Eligibility

2.1. **Emergency Services:** In keeping with the Emergency Medical Treatment and Labor Act (EMTALA), as amended from time to time, no determination of eligibility will be attempted until after an appropriate medical screening examination and necessary stabilizing treatment have been provided. If the patient requires Emergency Services, the determination of eligibility will be made after services have been rendered.

2.2. **Non-Emergency Services:** In non-emergency situations, the determination of eligibility for Financial Assistance will be made *before* providing services. If complete information on the patient's insurance or the responsible party's financial situation is unavailable prior to rendering services or at the time of services, the determination of eligibility will be made after rendering services. Community Hospital Anderson may require the service to be delayed until a determination can be made.

2.3. All efforts will be made to establish eligibility for Financial Assistance before the patient leaves the facility/first patient visit concludes.

3.0 Confidentiality and Participation

3.1. The need for Financial Assistance may be a sensitive and deeply personal issue for the patient/family. Confidentiality of information and preservation of individual dignity will be maintained for all who seek Financial Assistance. Orientation and training of staff and the selection of personnel who will implement this policy and procedure will be guided by these values. No information obtained in the Financial Assistance application may be released unless the patient/responsible party gives express written permission for such release.

3.2. **Staff Information:** All employees in patient registration, billing, collections, patient accounting, finance and emergency services areas will understand the fundamentals of the Financial Assistance Policy and be able to direct questions to the appropriate staff member(s).

3.3. **Staff Training:** All staff with public and patient contact will be trained to understand the basic information related to the Financial Assistance Policy

and will provide responsible parties with printed material explaining the Financial Assistance Program.

3.4. This section intentionally left blank

3.5. **Physician Participation:** We will encourage and support physicians not employed by Community who possess admitting privileges and others who provide services to our patients to establish and implement a Financial Assistance Program for the patients they see in connection with services rendered by Community. We will provide qualification status for individual patients upon request to physicians who are making efforts to financially clear their patient. Such communication will reveal minimum necessary information.

4.0 Collection Efforts

4.1. Notwithstanding any other provision of any other policy at Community regarding billing and collection matters, Community will not engage in any extraordinary collection actions before it makes reasonable efforts to determine whether an individual who has an unpaid bill from Community is eligible for financial assistance under this policy. The actions Community may take in the event of nonpayment and the process and timeframes for taking these actions are more fully described in Community's Billing and Collections Policy. A free copy of this policy may be obtained on line at www.communityanderson.com or by calling Customer Service at 765-298-3300.

4.1.1. For the purposes of this policy "Extraordinary efforts" include lawsuits, liens, garnishments or other collection efforts that are deemed extraordinary by the U.S. Department of Treasury or the Internal Revenue Service.

5.0 Notification/Duty to Inform - Community will undertake the following efforts to widely publicize its Financial Assistance Policy:

5.1. **Written Notification:** A conspicuous public display that attracts visitor's attention will be displayed in the emergency room and admissions' area. These signs will be of noticeable size. All publications and informational materials related to the Financial Assistance Program will be translated into languages appropriate to the population in the service area.

5.2. **Oral Notification:** All points of access will make every effort to inform each responsible party about the existence of Community's Financial Assistance Program in the appropriate language during any pre-admission, registration, admission or discharge process. Additionally, the post- service collection process will integrate notification of the availability of assistance into the standard process when collection efforts fail.

5.3. **Statement Notification:** Statements will provide information about the Financial Assistance Program.

5.4. This section intentionally left blank.

5.5. This section intentionally left blank.

5.6. Community will make a plain language summary of the policy available online at www.communityanderson.com. All publications and informational

materials related to the Financial Assistance Program published on the website will be translated into languages appropriate to the population in the service area. We will provide this website to any individual who asks how to access the plain language summary of the policy.

- 5.7. In partnership with Covering Kids and Family and the United Way of Madison County, Community Hospital Anderson will work to notify residents of the community served about our Financial Assistance Policy in a manner reasonably calculated to reach those members of the community.

6.0 Reporting and Record Keeping

- 6.1. This policy applies to Community Hospital Anderson as adopted by the applicable Boards of Directors and in accordance with the guidance provided by 501r requirements. The only exclusions to this are certain business units operating separate Financial Assistance Programs due to regulations or statutory requirements. Such entities are listed in Table 1.3.
- 6.2. Reporting: Reporting of Financial Assistance shall be in accordance with all applicable laws, rules and regulations, including Indiana Code 16-21-9-7 as amended and re-codified from time to time. Such report will be made available to the public upon request.
- 6.3. Corporate Responsibility: Each corporation's principal executive officer or officers and the principal financial officer or officers or persons performing similar functions will certify in each annual report that the signing officer has reviewed the report, and based on the officer's knowledge, the report does not contain any untrue statements of a material fact or omits to a material fact.
- 6.4. This section intentionally left blank
- 6.5. Internal Record Keeping: Application for Financial Assistance: When required, *completed* applications will be kept on file for at least five (5) years. A copy of the application and all correspondence regarding the application, approval, denial and/or appeal will be maintained and available in CHA's imaging system. All debt discharged shall be recorded in a manner that permits access to such information for record keeping, reporting and analysis purposes.
- 6.6. Automatic Discounts for the Uninsured: All automatic discounts for the Uninsured will be coded to specifically identify the discount as an "automatic discount for the Uninsured". Applicants who are determined to qualify for the applicable charity discount will not be provided the automatic discount for the uninsured.
- 6.7. Prohibition on Medical Record Documentation: No records will be placed in or notations made in a patient's health (medical) record regarding financial matters, including whether the patient paid all or part of any medical bills.

7.0 Extenuating Circumstances for Presumptive Eligibility

- 7.1. The financial clearance process may include investigation and collection of relevant documentation to verify available income from all qualifying sources (current and past), family size and other factors that may affect

Community Hospital Anderson's decision to extend charity care or assistance to an individual. Any individual that follows the financial clearance process and ultimately meets the Community Hospital Anderson's financial guidelines will receive free care or substantially discounted services according to the applicant's financial resources.

- 7.2. Generalized Patient Situation: The following are examples that can serve as guidelines for Charity Care consideration:
- Uninsured patients who lack the ability to pay
 - Insured patients who lack the ability to pay for services not covered by their insurer, excluding applicable insurer co-payments
 - Deceased patient without an estate
 - Unsupported disabled patient with little or no income
 - Patients involved in a medical catastrophe resulting in financial hardship
- 7.3. Interested Party Requests: Requests for consideration of discharge of debt may be proposed by sources other than the responsible party, such as the patient's physician(s), family members, community or religious groups, social services organizations or Community personnel. We will inform the responsible party of such a request and it will be processed as any other such request.
- 7.4. Conversion from Uninsured: When an uninsured patient has been given a discount on an account(s) under the "Uninsured Discount Policy" and the patient subsequently qualifies for free care for those accounts, total gross charges will be applied to the traditional Charity Care component of Community Benefit.
- 7.5. Presumptive Eligibility for Financial Assistance: There may be instances when a patient is unable to complete the financial assistance application and/or supply the necessary supporting documentation. In such cases, the financial counselor shall complete the enrollment form on behalf of a patient and search for evidence of financial need. For non-Medicare Traditional enrolled applicants, Community staff will use all available resources to verify such information including public databases, credit reports or other directories. Some examples include:
- Current enrollment in State assistance program (food stamps, welfare, certain pharmaceutical assistance programs, etc.) - AUTOMATIC Eligibility
 - Natural Disaster victim as designated by federally published zip codes - AUTOMATIC Eligibility.
 - Low-income housing resident, supported by a county appraisal district record - AUTOMATIC Eligibility
 - Patient is eligible for other unfunded state or local assistance programs
 - Patient receives free care from a community clinic and is referred to Community for further treatment
 - Unfavorable credit history (delinquent accounts, charge-offs,

bankruptcy filing within past year, no credit)

- Lack of family support for incapacitated patient.
- Mental incompetence as declared by a licensed medical professional
- A deceased patient with no estate and with no other responsible party for payment has met the criteria necessary for us to write-off the discharged debt to Charity Care

7.6. We will assume a homeless patient with no evidence of assets through communication with the patient, credit reports and other appropriate means, and with to the best of our knowledge, no responsible party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, has met the criteria necessary to write-off discharged debt to Charity Care. We will also assume an incarcerated person with more than a year to serve has no way of paying, and their debt will be discharged to Charity Care.

7.7. Terms of the Community Financial Assistance Program will only be applicable to those individuals who are demonstrated to be citizens of the United States or legally documented aliens and have provided proof of citizenship or legal status as needed.

7.8. When a Medicaid patient is admitted for inpatient or outpatient services and has unpaid accounts for dates of service within thirty (30) days prior to the patient's Medicaid effective date, and to the best of our knowledge there is no responsible party, financial assistance from a Government Benefit Plan or Government Sponsored Health Care for the Indigent for payment, we will assume the patient has met the criteria necessary to write-off the discharged debt to Charity Care.

7.9. Upon verbal confirmation of family size and income by the applicant, outside financial information, such as "propensity to pay" scoring information provided by an outside vendor, may be used as a screening tool for the manual verification of eligibility for the Community Financial Assistance Program.

8.0 Program Administration and Process

8.1. Financial Assistance Application: Upon request from Community, the Financial Assistance Application must be completed by the patient, or the financial counselor on their behalf, and submitted for review before financial assistance will be considered (See ***Attachment B, Financial Assistance Program Application***). The following items may be requested to substantiate financial need of an individual patient:

- Recent W-2s, recent payment stub to verify income level, previous year's tax forms, bank or credit union statements for checking and savings accounts and other statements from financial or legal institutions to verify additional sources of qualifying income.
- External data that provides information on a patient's or guarantor's ability to pay.
- Proof of non-qualification for any other State/Government Financial Assistance Programs (i.e., Medicaid or other grant-based county or

- city programs).
- 8.2. Substantial effort will be made by Community and its business associates to identify alternative sources of payment via patient qualification from other programs before financial assistance will be granted. This effort will require cooperation from the patient/guarantor. Lack of cooperation with this phase of the determination process will disqualify the patient from Community Hospital Anderson's Financial Assistance Program.
 - 8.3. Collection of Family Size and Income Data are the key drivers of the calculation to determine qualification for financial assistance. Community's definitions of family size and income are located in the "Definitions" section of this policy. For purposes of determining the scope of documentation required with the application:
 - 8.3.1. When the patient is a non-emancipated minor: Biological mother and father and/or step parent(s) if child is adopted and all persons on the tax return(s), filer(s) and dependents of same; or, in the event that that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).
 - 8.3.2. When the patient is not a minor or is an emancipated minor: The patient, the spouse and the dependents of same on the tax return(s) of the patient and/or spouse; or, in the event that another person not listed herein signed for financial responsibility, the person who signed plus the spouse and all dependents on that person(s) tax return(s).
 - 8.4. Family income, family size, FPL% and other data may be obtained and used to corroborate provided details leading to eligibility for Community's Financial Assistance Program.
 - 8.5. Assistance Basis: The basis for Community's Financial Assistance Program is the Federal Poverty Level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services. The calculation of the financial assistance discount is a conversion of the patient's basic demographic information (monthly family income and family size) into a % of FPL.
 - 8.6. Assistance Levels: For uninsured and underinsured applicants, a sliding scale assistance protocol will be applied to each patient account as follows:
 - Patients (applicants) with income levels less than 100% of the current year's Federal Poverty Level (FPL) will qualify for 100% financial assistance.
 - Patients (applicants) with income levels between 101% to 200% will have a patient portion of \$25 for each Outpatient account and \$50 for each ER, IP or Observation account.
 - Patients (applicants) with income levels ranging from 201% to 300% of the current year's federal poverty level (FPL) will qualify for partial assistance determined by a sliding scale detailed in table 1.1.

- Patients (applicants) with income levels greater than 300% of Federal Poverty Level (FPL) will not be eligible for the Financial Assistance Program unless approved by the Revenue Cycle Director. These patients may be eligible to receive discounted rates on a case-by-case basis based on their specific situation, such as catastrophic illness, at the discretion of Community.
 - Patients (applicants) who are uninsured and do not meet these income requirements will receive a discount of 60% on gross charges based on Amount Generally Billable (AGB) for medically necessary and emergency care services they receive.
- 8.7. Liability Limitation: Responsible parties who do not qualify for financial assistance (>300% of the FPL) will have medical/dental debt per calendar year limited to twenty-five percent (25%) of their annual family income. In such cases, the patient must present all medical bills for the 12 months immediately preceding the application date or the medical debt must be evidenced in Community's patient accounting system. At the point where the 25% threshold has been met during this 12 month period, Community will limit further liability for services provided within the network that are subject to the terms of the Financial Assistance Program. It is the patient's or guarantor's responsibility to declare financial hardship.
- 8.8. This section is intentionally left blank.
- 8.9. Financial Assistance Coverage Date Span: It is preferred, but not required, that a request for Charity Care and a determination of financial need occur prior to the rendering of services. However, the determination may be completed at any point during the collection cycle. The following restrictions apply:
- 8.9.1. Financial Assistance applications must be received within 240 days (120 days Notification Period + 120 days Application Period) from first patient statement to be considered for provision of financial assistance. Upon receipt of application within notated Application Period, extraordinary collection actions will cease. Patient must cooperate with submitting supporting documentation upon request within a reasonable timeframe.
- 8.9.2. Intentionally Left Blank
- 8.10. Application Process: An application for financial assistance will be provided to any requesting party. This may be done in person or by mail. Assistance in completing the application will be available and provided to the responsible party as required and such inquiries may be directed to Customer Service at (765) 298-3300. If the qualification for financial assistance cannot be determined through the use of external databases or other programs designed to establish financial need, the patient will also be provided a list of additional documentation that will be required to substantiate their financial situation. If required, the application and all required supplemental documentation must be received before a decision can be made regarding the provision of financial assistance.

- 8.11. The responsible party (“applicant”) will have fifteen (15) calendar days following the initial date of request on the application to complete and return the application. The applicant may request an extension of fifteen (15) calendar days for good cause and such extension shall not be unreasonably denied. Failure to return a complete application within said fifteen (15) days or, if extended, thirty (30) days may result in denial of the application and no discharge of debt.
- 8.12. This section intentionally left blank
- 8.13. Using the documentation provided or results determined through the use of external databases or other programs designed to establish financial need, the Financial Counselor will use the current year’s Financial Assistance Program criteria to determine the “scope of eligibility” as detailed in this policy.
- 8.14. Patient Approval/Denial Notification Requirements: Upon receipt of a complete application or analysis of information provided by external databases or other programs designed to establish financial need, it will be approved or denied within thirty (30) days following the date of receipt. The applicant will be given or mailed a letter indicating approval or denial and, if approved, the amount of debt discharged, any balance due and the date due.
- 8.15. This section intentionally Left Blank

Table 1.1
Sliding Scale for Charity Discounts

Calculated % of FPL	Discount %
≤ 200%	100%
201%-225%	90%
226%-250%	80%
251%-275%	70%
276%-300%	60%

Table 1.2
Eligible Providers

In addition to care delivered at Community Hospital Anderson’s facility, emergency and medically necessary care delivered by the providers listed below are covered under a similar policy through Community Health Network. Information about their policy may be found at www.ecommunity.com or by calling 317-355-5555.

Community Health Network Physicians

Table 1.3

Care provided by any of the providers listed below at Community Hospital Anderson will NOT be covered under this policy since they are not employed by Community Hospital Anderson. As such, the bills received by Community Hospital Anderson patients for care provided by any of the following providers will NOT be eligible for the discounts described in the Financial Assistance Program. The patient may contact the provider directly to see if there are discounts or assistance available from the provider

Northside Radiology Consultants, LLC
Intensivists, Dr. Malik and Dr. Kabir
Community Anesthesia Associates
Emergency Physicians of Community Hospital Anderson
Community Pathology and Nuclear Medicine, PC
Urology of Indiana
Josephson, Wallack, Munshower Neurology (JWM)
Central Indiana Orthopedics (CIO)

Approved By:
Chief Financial Officer
Effective Date: January 1, 2016



APPLICATION FOR FINANCIAL ASSISTANCE

Thank you for choosing Community Hospital Anderson to serve your health care needs and for expressing interest in our Financial Assistance Program.

Please complete this application and return it along with all supplemental documentation required within thirty (30) days to avoid possible denial of your application. The information you provide will be held in strict confidence and will not be used for any purpose other than to assess your need for financial assistance. We will not share this information with any person or organization outside of Community Hospital Anderson. Furthermore, the information may be sent to Community Health Network and other medical providers as a result from your stay with Community Hospital Anderson at applicant's request.

Please provide the following information so we can better understand how many people are in your family. Dependents may live outside of your primary household residence if they are claimed on your (or your spouse's) Federal income tax return.

APPLICANT NAME _____ TELEPHONE # _____
 DATE OF BIRTH _____
 SOCIAL SECURITY NUMBER _____ - _____ - _____
 EMAIL _____
 STREET ADDRESS _____ CITY _____
 STATE _____ ZIP _____

SPOUSE / DEPENDENT FAMILY INFORMATION (include an additional page if more space is required to list dependent family members)

NAME	RELATIONSHIP	SSN	DATE OF BIRTH

FAMILY FINANCIAL INFORMATION

What is your monthly household, pre-tax (gross), spendable income from all sources such as, but not limited to: wages, salaries, tips, commissions, pensions, Social Security, interest, investments, rent, royalties, disability benefits, unemployment compensation, etc.?
 \$ _____

Please submit unaltered copies of the following documents:

- The first two (2) pages of your most recent FEDERAL 1040 TAX RETURN and your spouse's if you filed separately. [If anyone is self-employed a copy of the complete FEDERAL 1040 TAX RETURN must be included.]
- The last three (3) paycheck stubs for all income earners in the household (including verification of Social Security, pensions, unemployment compensation, etc.).
- Bank statements (both checking and savings) for the past three (3) months for all accounts in the household including business accounts.
- Proof of food stamps, HUD, or TANF.



APPLICATION FOR FINANCIAL ASSISTANCE

ADDITIONAL QUALIFICATION INFORMATION

I/WE CERTIFY that the information provided is a true and accurate representation of my/our family size and household income. Community Hospital Anderson is authorized to check my/our credit and employment history and to answer questions as to your credit experience with me/us. I/we understand that any misrepresentation of this information will result in a denial of financial assistance.

Applicant/Guarantor Signature _____

Date _____

Co-Applicant/Spouse Signature _____

Date _____

Please return your completed application and all supporting documentation in the postage-paid envelope provided. Mailing address is: 1515 N Madison Ave, Anderson, IN 46011. Customer Service for any questions or assistance with this application: 765.298.3300.

PLAIN LANGUAGE SUMMARY COMMUNITY HOSPITAL ANDERSON'S FINANCIAL ASSISTANCE POLICY

Overview

Community Hospital Anderson is committed to offering financial assistance to people who have health care needs and are not able to pay for care. You may be able to get financial assistance if you do not have health insurance or the portion of your bill not covered by insurance is more than you can afford to pay. Please note that there are certain service exclusions that are not typically eligible for financial assistance, including but not limited to cosmetic services and other services that are not medically necessary. This is a summary of the Community Anderson's Financial Assistance Policy (FAP).

Eligibility Requirements

Financial assistance is generally determined by a sliding scale of total household income based on the *Federal Poverty Level (FPL)*. If you and/or the responsible party's family income combined is at or below 200% of the federal poverty guidelines, you may have no financial responsibility for the care given by Community Anderson. If you fall between 200% and 300%, you may get discounted rates for the care given by us. No person eligible for financial assistance under the FAP will be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance covering such care. If you have sufficient insurance coverage or assets available to pay for your care, you may not be eligible for financial assistance. Please refer to the full policy for a complete explanation and details.

Where to Find Information and How to Apply

There are many ways to find information about the FAP application process or get copies of the FAP or FAP application form. To apply for financial assistance, you may:

1. Download an application at www.communityanderson.com
2. Request the information in writing by mail or by visiting Community Hospital Anderson's Emergency Department Front desk at 1515 N. Madison Ave, Anderson, IN 46011
3. Request the information by calling 765-298-3300
4. Request the information by email at financialhelp@ecommunity.com

You will then need to mail all requested information, including the supporting documentation, to Patient Accounts, Community Hospital Anderson, 1515 N. Madison Ave, Anderson IN 46011 or deliver in person to Patient Accounts in the basement of the 1601 building on Medical Arts Blvd, Anderson, IN.

We have Financial Counselors available to help you complete the application or answer questions you have about our FAP. Please call 765-298-3300.