NTC COMMUNITY CLINIC (NTCCC)

SUBJECT: FINANCIAL HARDSHIP ***EFFECTIVE DATE: 04/16/13***

APPROVED: 4/16/2013

PURPOSE:

It is the policy of NTCCC that patients experiencing financial hardship may apply for a discount or waiver of the patient's financial responsibility (e.g., copayment, coinsurance, and/or deductible). Whether or not such a discount or waiver is granted shall be based on an individual assessment of the patient's financial circumstances, and an assessment of NTCCC's legal and contractual obligations to the third-party payers.

PROCEDURE:

1. NTCCC does not advertise its financial hardship discount program, nor does it routinely offer discounts or waivers to patients.
2. NTCCC determines whether the patient is a beneficiary of a private third-party payer plan. If appropriate, NTCCC determines whether its agreement with the payer prohibits a financial hardship waiver or discount.
3. In order to be considered for a discretionary discount or waiver, individualized documentation of financial hardship must be included in the patient's medical record and a supporting note in the patient's financial account. The documentation needed to apply for a financial hardship discount or waiver is listed below:
    a. A completed Patient Financial Assessment Form (see below).
    b. One or more of the following:
        i. Documented proof that a patient is at or below 150 percent of the current federal poverty guidelines as published annually by the U.S. Department of Health and Human Services. Documented proof may include documents such as W-2 withholding statements, unemployment check stubs, pay check stubs, income tax return (1040), forms from Medicaid or other State-funded medical assistance, forms from employers, and/or welfare or community agencies; or
        ii. Documentation that a patient has other circumstances that indicate financial hardship, which may include, but not be limited to, proof of bankruptcy settlement, catastrophic situations (for example, death or disability in family) or another documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses. NTCCC Tribal Health Director will be responsible for considering the grant or denial of hardship status under these circumstances on a case-by-case basis. Documentation must be submitted for the review.
    c. Income shall be annualized from the date of request based on the documentation provided and upon verbal information provided by the patient. The annualization will also take into consideration seasonal employment and temporary increases and/or decreases to income.
4. Discounts or waivers for Medicare beneficiaries shall be applied only to the coinsurance or deductible amounts owed by the patient. Discounts for Medicaid beneficiaries shall be determined in accordance with applicable state law.
5. Any denial of the financial hardship discount or waiver request is documented and includes instructions for reconsideration. If additional documentation is received to support the financial

hardship, the request will be reviewed and considered per the above guidelines. The decision of the Tribal Health Director is final.

6. All information relating to financial hardship requests will be kept confidential, except insofar as required by law.

PATIENT FINANCIAL ASSESSMENT FORM

Date: _____ Account #: _____

Social Security #: _____

Patient Last Name: _____ First Name: _____

Address: _____City: _____ State: ____ ZIP Code: _____

Phone: _____ Alternate Phone: _____

Name of responsible party (if not patient, print name of Guarantor): _____

Patient Employer: _____ Employer Phone: _____

Employer Address: _____City: _____ State: ___ ZIP Code: _____

Length of Employment: _____If unemployed, last date of employment: _____

Spouse Last Name: _____ First Name: _____

Spouse Employer: _____ Employer Phone: _____

Employer Address: _____City: _____ State: ___ ZIP Code: _____

Length of Employment: _____If unemployed, last date of employment: _____

Total in household (include yourself): Adults (18+) _____ Minors (under 18) _____

Guarantor (responsible party) Employer: _____ Phone: _____

Employer Address: _____City: _____ State: ___ ZIP Code: _____

Length of Employment: _____If unemployed, last date of employment: _____

Income (monthly)	Patient	Spouse	Responsible Party (Whom)	Children Working
Gross Monthly Salary	$	$	$	$
Public Assistance Benefits	$	$	$	$
Unemployment	$	$	$	$

Benefits				
Social Security Benefits	$	$	$	$
Workers' Compensation	$	$	$	$
Child Support	$	$	$	$
Other (Alimony, Pension, Life Insurance, VA Benefits, Disability)	$	$	$	$

Other Assistance: _____

Have you applied for Medicaid: Yes No (circle)

If 'yes,' provide current status or attach denial letter: _____

Have you tried to obtain financial assistance from other organizations? Yes No (circle)

List the organizations and current status:

_____

List all outstanding hospital/physician bills:

1. _____

2. _____

3. _____

4. _____

5. _____

Please provide any additional information/comments:
(attach additional sheet if more space is required, or use back of this form.)

_____

Financial Documentation: (attach copies)

Previous year 1040 IRS: $_____ Year _____

W-2s: $_____ Year _____

If patient claims income is less than the previous calendar year tax form; attach most recent four pay stubs.

$ _____ Date _____
$ _____ Date _____
$ _____ Date _____
$ _____ Date _____

	Monthly Payment		**Credit Limit**	**Balance**	**Monthly Payment**
Mortgage/Rent	$	VISA	$_____	$_____	$_____
Gas & Electric	$	MC	$_____	$_____	$_____
Telephone	$	AMEX	$_____	$_____	$_____
Car Insurance	$	Discover	$_____	$_____	$_____
Car Payment			$		
Food	$	Other Expenses (Provide Explanation)			
Total Monthly Expenses This Column	$	_____			$_____
Total Monthly Expenses Other Column	$	_____			$_____
Monthly Expense Grand Total	$	_____			$_____
Yearly Household Income		Total		$_____	

Gross: $
Net: $

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Total wages for calendar year: $ _____

Total Household: $ _____

Check when completed:
Discount Screen o
Patient Alert(s) o
Added to practice management system o

Eligible Discount: $ _____

Date Completed:_____ By: _____

Notes: _____ __

Name/Phone: _____

_____ _____