Holy Cross Hospital

Financial Assistance and Charity Care Policy

In the spirit of our mission to serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities, Holy Cross Hospital, a member of Trinity Health, is committed to providing health-care services to all patients based on medical necessity.

For patients who require financial assistance or who are experiencing temporary financial hardship, Holy Cross Hospital offers several assistance and payment options, including charity and discounted care, short term and long term payment plans and online patient portal payment capabilities.

Uninsured Patients

Holy Cross Hospital extends discounts to all uninsured patients who receive medically necessary services. Uninsured discount amounts are based on Federal Poverty Level (FPL) guidelines. Patient statements will show the discount amount and the adjusted balance owed.

Services such as cosmetic procedures, hearing aids and eye care that normally are not covered by insurance are priced at package rates with no additional discount. All payments are expected at the time of service.

Short-Term and Long Term Payment Plans

Patients who cannot pay some or all of their financial responsibility may qualify for short term or long term payment plans. Holy Cross Hospital's short term payment plan is interest free and patient balances must be paid within one year. Longer term interest bearing payment plans are available for those patients who cannot pay their balances within one year.

Financial Assistance / Charity Care Policy

A 100 percent discount for medically necessary services is available to patients who earn 200 percent or less of the Federal Poverty Level guidelines. Elective services such as cosmetic surgery are not included in our charity program. Those who earn between 200 and 400 percent of the Federal Poverty Level guidelines may be eligible for a partial discount equal to the Medicare discount rate. Patients who qualify for financial assistance will not be charged more than the Medicare discount rate.

Patient copays and deductibles may be eligible for discounted rates if a patient qualifies for financial assistance and earns less than 200 percent of the Federal Poverty Level Guidelines.

Discounts are also available for those patients who are facing catastrophic costs associated with their medical care. Catastrophic costs occur when a patient's medical expenses for an episode of care exceed 20% of their income. In these cases patient copays and deductibles may also be included in the discount.

Charity care discounts may be denied if patients are eligible for other funding sources such as a Health Insurance Exchange plan or Medicaid eligibility and refuse or are unwilling to apply.

To apply for financial assistance, please complete and submit the application found on this webpage (https://www.holy-cross.com/billing-insurance). A complete version of the Holy Cross Hospital Financial Assistance Policy is also available on this webpage.

Patient Financial Services

Financial counselors are available to work with patients in completing financial assistance applications in order to determine what assistance is available. This includes assessing eligibility for Medicaid and Health Insurance Exchange plans.

Patients may contact a financial counselor at the hospital where they have care who can assist in determining qualifications for financial assistance. Financial counselors can also provide free copies of the Financial Assistance Policy, Application, and Plain Language Summary. (The Financial Counseling Department is located on the main campus at Holy Cross Hospital at 4725 North Federal Highway, Fort Lauderdale, FL 33308. The phone number is (954)267-7771.The Financial Assistance Policy, Application and Plain Language Summary are translated into the following languages: Spanish.

The Health Insurance Marketplace

The Affordable Care Act (ACA) requires everyone legally living in the U.S. to have health insurance beginning January 1, 2014. It also gives millions of individuals with too little or no insurance, access to health plans at different cost levels. The law also provides financial assistance to those who qualify based on family size and income. Beginning October 1, 2013, you will be able to shop at a new online Health Insurance Marketplace, also known as a health insurance exchange, where you can one-stop-shop for a plan that fits your budget and coverage needs. The next open enrollment for the health insurance exchange marketplace is in November 2017.

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REQUIRED DOCUMENTATION FOR FINANCIAL ASSISTANCE ELIGIBILITY

Patient Name _____ Account Number _____

A copy of your entire Income Taxes or 1099 forms for the year of _____.

Note: If you did not file taxes for the previous year, please contact the IRS at 1-800-829-1040 and obtain a letter of "Non-Filing for _____" or go to www.irs.gov/pub/irs-fill/f4506

_____ A copy of your most recent bank statements reflecting all transactions for the last three (3) months. Documentation must be in the bank's statement format and must include name, address, and account number. All pages are required. Please include all checking accounts and savings accounts.

_____ Copy of your most recent payroll check stub or a letter from your employer documenting your salary. If you are unemployed, we require a copy of your Unemployment Compensation Benefits Determination Letter.

_____ Alimony or Child Support Determination Letter(s) Check one □ Yes □ No

_____ Food Stamp Determination Letter Check one □ Yes □ No

_____ Letter from Social Security/Disability/Pension documenting the income benefit amount you are currently receiving monthly (if applicable)

_____ Completed and signed *Application Form* (attached)

Completed, signed, and notarized (by a Notary Public) *Attestation Form*.

_____ *Note: Notary service is available at Holy Cross Hospital

_____ Completed, signed, and notarized *Support Letter* by your guarantor or person(s) supporting you

Apply for Medicaid. Provide Approval or Denial Determination Letter.

_____ Medicaid website: www.myflorida.com/accessflorida or call 866-762-2237

_____ Copy of valid photo identification – Driver's License, Passport, Work ID. The photograph must be clear and the identification not expired.

_____ Proof of residency in the Service Area (rental agreement, utility bill, invoice). See Holy Cross Hospital Service Area matrix.

_____ Completed, signed and notarized *No Financial Banking Affidavit Form*

_____ Apply for the insurance through the Affordable Care Act Health Insurance Marketplace at www.healthcare.gov or call 800-318-2596. Provide the determination letter.

_____ Explanation of bank statements with cash deposits or withdraws of amounts greater than $200.

_____

_____

All of the information above is required to process your Request for Financial Assistance.

Application Period begins the day that care is provided and ends the later of 240 days after the first post-discharge billing statement is provided to the patient or either --

i. the end of the 30 day period that patients who qualified for less than the most generous assistance available based upon presumptive support status or prior FAP eligibility are provided to apply for more generous assistance.
ii. the deadline provided in a written notice after which ECAs may be initiated (30 days from the receipt of the FAP Application)

_____ Financial Assistance/Charity Coordinator
954-267-7780

_____ Mailing Date of Request

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STATEMENT OF FINANCIAL CONDITION

Section 1: Demographic Information

Last Name	First Name	MI	Social Security Number	Date of Birth

Home Telephone #	Emergency Contact Telephone #	Alternate Telephone #

Street Address	City	State	Zip Code

Section 2: Employer Information

Your Employer Name	Employer Telephone #

Street Address	City	State	Zip Code

Spouse Employer Name	Spouse Employer Telephone #

Street Address	City	State	Zip Code

Section 3: Income & Expense Information

Last 12 Months Gross Income	Patient	Spouse
Gross Income	$	$
Other Family Income	$	$
Interest & Dividends	$	$
Real Estate or Personal Property	$	$
Social Security	$	$
State Financial Assistance	$	$
Other Income (specify)	$	$
Alimony or Child Support Payments	$	$
Current Monthly Income	$	$
Total Combined Income	$	$

Expenses	Monthly	Payment
Rent □ Own □	Monthly	$
Utilities	Monthly	$
Food	Monthly	$
Other Expenses	Monthly	$
Total Monthly Expenses		$

Other Considerations	Yes	No
Family Size: _____		
Child Care/Babysitter		
Single Parent Caring for Elders		
Cost to Provide Services Exceeds 3rd Party Reimbursement		
Emergency Services		

	Yes	No
If patient is deceased, is there an estate		
Was your medical condition a result of an accident or injury?		
Have you retained an attorney (If yes, list name and phone #)		

By signing this form I agree to allow Holy Cross Hospital and/or Holy Cross medical group to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount. I understand that I may be required to provide proof of the information listed on the application. I certify that the above information is true and accurate to the best of my knowledge. Further, I understand that I am to apply for any assistance via State County or federal funding, which may be available for payment of my hospital visit, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

I understand that this charity application applies only to the dates of service and corresponding account numbers referenced on this application for Holy Cross Hospital and Holy Cross Medical Group and that I may incur additional charges from other professional entities of which I will be responsible including but not limited to Anesthesiologists, Radiologists and Pathologists. Unless patient requires a course of treatment based on one diagnosis a new, charity form must be submitted for every date of service.

Applicant's Signature _____ Date of Request _____

Reviewed By _____ Date of Review _____

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FINANCIAL ASSISTANCE INCOME INDIGENCY ATTESTATION STATEMENT

Patient Name _____ Account Number _____

I,_____ certify, under the penalty of law that my family income for the past twelve (12) months has been $_____, and that there are ____ people in my household/immediate family. I certify that I reside in the following zip code _____ and _____ (Country).

This income can be verified by calling the following employer(s):

Company Name _____ Telephone # _____
*Note: Write 'Unemployed' if not employed

Additionally, I understand that in accordance with S.817.50, providing false information to defraud a hospital for the purpose of obtaining goods and services is a misdemeanor in the second degree.

By signing this form, I agree to allow Holy Cross Hospital to check employment and credit history for the purpose of determining my eligibility for financial assistance or a financial discount.

Guarantor Printed Name _____ Guarantor Signature/Date _____

Witness Printed Name _____ Witness Signature/Date _____

Witness Relationship to Patient _____

State of Florida

County of Broward

The foregoing instrument was acknowledged by before me this _____
by _____, who is personally known to me or who has proved
_____ as identification and who did/did not take an oath.

Notary Public _____ Date _____

Holy Cross Hospital

NO FINANCIAL BANKING AFFIDAVIT

Patient Name _____ Account Number _____

I _____ certify that

I do_____ I do not_____ have a Bank Account anywhere in the United States of America.

Signature _____ Date _____

State of Florida

County of Broward

Subscribed and sworn to me before this_____day of _____
_____, who is personally known to me or who has proved
_____as identification and who did/did not take an oath.

Notary Public _____ Date _____

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LETTER OF SUPPORT

_____ _____
Patient Name Account Number

This is to certify that I _____ being the _____
Name Relationship

of the above patient, do provide **free** room at board at _____

for the past _____ **years/months**.

Check the box of the living expenses that you provide:

Rent □	Mortgage □	Food □	Clothes □
Utilities □	Car Insurance □	Gas □	Medicine □
Money □			

Cash Assistance

How much money was given to the patient on a weekly or monthly basis $_____

How long was the patient provided with the money _____

_____ _____
Signature Of Supporter Date

State of Florida

County of Broward

Subscribed and sworn to me before this_____day of _____
_____, who is personally known to me or who has proved
_____as identification and who did/did not take an oath.

_____ _____
Notary Public Date