



# 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.

## REQUESTED DOCUMENTATION FOR FINANCIAL ASSISTANCE ELIGIBILITY

Patient Name	Account Number
_____	_____
<p>A copy of your entire Income Taxes or 1099 forms for the year of _____.</p> <p>*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 <a href="http://www.irs.gov/pub/irs-fill/f4506">www.irs.gov/pub/irs-fill/f4506</a>*</p>	
<p>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 (please provide explanation for deposits over \$200.00)</p>	
<p>Copy of your most recent payroll check stub or a letter from your employer documenting your salary. If you are unemployed, we request a copy of your Unemployment Compensation Benefits Determination Letter.</p>	
<p>Alimony or Child Support Determination Letter(s)    Check one <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	
<p>Letter from Social Security/Disability/Pension documenting the income benefit amount you are currently receiving monthly (if applicable).</p>	
<p>Completed and signed <i>Application Form</i> (attached).</p>	
<p>Completed and signed <i>Attestation Form</i> (attached).</p>	
<p>Completed and signed <i>Support Letter</i> by your guarantor or person(s) supporting you.</p>	
<p>Apply for Medicaid. Provide Approval or Denial Determination Letter. Please include Food Assistance determination letter (if applicable).</p>	
<p>Medicaid website: <a href="http://www.myflorida.com/accessflorida">www.myflorida.com/accessflorida</a> or call 866-762-2237</p>	
<p>Copy of valid photo identification (if not on file) – Driver's License, Passport, Work ID. The photograph must be clear and the identification not expired.</p>	
<p>Proof of residency (at least 6 months) in the Service Area (rental agreement, utility bill, invoice). See Holy Cross Hospital Service Area matrix.</p>	
<p>Completed and signed <i>No Financial Banking Affidavit Form</i>.</p>	
<p>Apply for the insurance through the Affordable Care Act Health Insurance Marketplace at <a href="http://www.healthcare.gov">www.healthcare.gov</a> or call 800-318-2596 (if applicable) Please provide the determination letter. Holy Cross has ACA Marketplace navigators on-site during open enrollment in November and December.</p>	

All of the information above is requested to process your Request for Financial Assistance (partial applications will be reviewed on a case-by-case basis.)

**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
--	-------------------------



## STATEMENT OF FINANCIAL CONDITION

### Section 1: Demographic Information

Last Name	First Name	MI	Social Security Number	Date of Birth
Home Telephone #		Alternate Telephone #		
Street Address		City	State	Zip Code

### Section 2: Employer Information

Your Employer Name	
City	State
Spouse Employer Name	
City	State

### Section 3: Income & Asset Information

Last 12 Months Gross Income	Patient	Household (spouse, partner, etc.)
Gross Income	\$	\$
Interest & Dividends	\$	\$
Real Estate or Rental Income	\$	\$
Social Security/Disability/Pension	\$	\$
State Financial Assistance	\$	\$
Other Income (specify)	\$	\$
Alimony or Child Support Payments	\$	\$
Current Monthly Income	\$	\$
<b>Total Combined Income</b>	<b>\$</b>	<b>\$</b>

Other Assets	
Stocks, Bonds, Mutual Funds, etc.	\$
Property value(s)	\$
Vehicle value(s)	\$
<b>Total Assets</b>	<b>\$</b>

**Comments:**

Other Considerations	Yes	No
Household Size: _____		
Property Ownership		
Vehicle Ownership		
Cost to Provide Services Exceeds 3 <sup>rd</sup> Party Reimbursement (catastrophic care)		

	Yes	No
If patient is deceased, is there an estate?		
Was your medical condition a result of an accident or injury? (i.e. Emergency Services)		
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



**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

**LETTER OF SUPPORT**\_\_\_\_\_  
Patient Name\_\_\_\_\_  
Account NumberThis is to certify that I \_\_\_\_\_ being the \_\_\_\_\_  
Name Relationshipof 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	<input type="checkbox"/>	Mortgage	<input type="checkbox"/>	Food	<input type="checkbox"/>	Clothes	<input type="checkbox"/>
Utilities	<input type="checkbox"/>	Car Insurance	<input type="checkbox"/>	Gas	<input type="checkbox"/>	Medicine	<input type="checkbox"/>
Money	<input type="checkbox"/>						

**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



**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