PATIENT NOTICE OF FINANCIAL AID

Pocahontas Memorial Hospital takes pride in its mission to provide care to all who need it. If you are not able to fully pay for your care, we may be able to help by providing aid to those who qualify for assistance, or helping to get low-cost health insurance. Therefore, it is important to let us know if you might have trouble paying your bill, particularly since we are required to seek full payment for services provided. This means that we must turn unpaid bills over to collection agencies if there is no agreement on a payment plan. If you think you qualify for aid, complete the form below to apply. Our staff will be happy to help.

APPLICATIONS FOR DISCOUNT PROGRAM

1. _____ (patient name) of _____
_____
(patient address/telephone number) hereby requests that the fees, as described below, be discounted.

2. Hospital service description and date of service _____
_____
_____.

3. Dollar amount of the fees requested to be discounted_____.

4. Reason and rationale for the request _____
_____.

5. If the request for discount fees is because of a claim of financial hardship, please obtain a copy of the family's most recent income tax return, attach a copy of that document to this form, and document in the space provided whether the patient meets the "300% of the current federal poverty guidelines" review the table below against your income tax return or other documentation acceptable to the Hospital (as determined by the Income-Based Discount Program Policy Committee on a case-by-case basis).

		% of Federal Poverty Level Income										
		300%	310%	320%	330%	340%	350%	360%	370%	380%	390%	>400%
Size of	FPL	Approved % of Financial Assistance										
Family Unit	Income	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
1	$12,140	$36,420	$37,634	$38,848	$40,062	$41,276	$42,490	$43,704	$44,918	$46,132	$47,346	$48,560
2	$16,460	$49,380	$51,026	$52,672	$54,318	$55,964	$57,610	$59,256	$60,902	$62,548	$64,194	$65,840
3	$20,780	$62,340	$64,418	$66,496	$68,574	$70,652	$72,730	$74,808	$76,886	$78,964	$81,042	$83,120
4	$25,100	$75,300	$77,810	$80,320	$82,830	$85,340	$87,850	$90,360	$92,870	$95,380	$97,890	$100,400
5	$29,420	$88,260	$91,202	$94,144	$97,086	$100,028	$102,970	$105,912	$108,854	$111,796	$114,738	$117,680
6	$33,740	$101,220	$104,594	$107,968	$111,342	$114,716	$118,090	$121,464	$124,838	$128,212	$131,586	$134,960
7	$38,060	$114,180	$117,986	$121,792	$125,598	$129,404	$133,210	$137,016	$140,822	$144,628	$148,434	$152,240
8	$42,380	$127,140	$131,378	$135,616	$139,854	$144,092	$148,330	$152,568	$156,806	$161,044	$165,282	$169,520

*Note: For family units of more than 8 persons, add $4,320 for each additional person.

Source: Federal Register, Vol. 83, No. 12, January 18, 2018, pp. 2642-2644.

6. Number of persons in the patient's Family Unit _____ Total Yearly Family Income $_____

7. I _____, do attest that the information is factual and correct to the best of my knowledge.

Patient Signature_____ **Date**_____

Office Use Only

Patient Account Representative Signature_____ Date_____

Exoneration Committee Signature_____ Date_____

Revised 08/01/2018

YOU MUST PROVIDE PROOF OF INCOME

Return copies of proof of income for all items listed below that may apply to you:

*MEDICAID DENIAL

*PAYROLL CHECKS

*SOCIAL SECURITY INCOME

*SSI

*CHILD SUPPORT

*UNEMPLOYMENT COMPENSATION

*ALIMONY

*PENSIONS

*STRIKE BENEFITS

*AFDC

*RAILROAD RETIREMENT

*VA BENEFITS

*SELF-EMPLOYMENT INCOME

*FOOD STAMPS

*FEDERAL AND STATE TAX RETURNS FOR THE CURRENT YEAR **MUST BE INCLUDED**

*CHILD CARE INCOME

*ANY OTHER SOURCE OF INCOME NOT LISTED ABOVE

PLEASE RETURN ANY OF THE ABOVE AT THE TIME YOU RETURN YOUR INCOME BASED DISCOUNT PROGRAM APPLICATION

YOUR APPLICATION WILL NOT BE CONSIDERED WITHOUT PROOF OF INCOME