Financial Hardship Application Instructions

Dear Applicant,

Please review the steps below before filling out the attached forms:

1. Read and review Freedom Mobility Center's *Policy and Procedure: Waiver of Deductible and Copayments* (attachment A).

2. Read the *Financial Hardship Application Guidelines* (attachment B).

3. Refer to the Poverty Guidelines as listed by the U. S. Department of Health and Human Services to assist you in determining whether you may be eligible for a payment plan or waiver (review table on attachment D).

4. Fill out the *Financial Hardship Form* and then sign and date (see attachment C). If you are unable to sign, an authorized representative can sign for you.

5. Mail back the *Financial Hardship Form along with* any additional documentation (if applicable) in the postage-paid return envelope we've provided.

If you have any difficulty filling out the form, please feel free to contact one of our customer service representatives to assist you.

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Attachment A

POLICY AND PROCEDURE: WAIVER OF DEDUCTIBLES AND COPAYMENTS

Policy: Copayment and deductible amounts that are the patient's responsibility under the rules of the Medicare or Medi-Cal program or any other governmental or commercial third-party payor may not be waived, except on a case-by-case basis upon a determination of financial need. Routine waiver of copayment and deductible amounts is a violation of federal law and Freedom Mobility Center's policy.

Procedure:

Application: A patient or representative of a patient who requests waiver of a copayment or deductible will be asked to complete a Financial Hardship Application (form attached). The Branch Manager will review the Application in accordance with this policy and procedure. Only the Branch Manager has the authority to approve waiver of a copayment or deductible.

Income guidelines: If the patient does not have secondary insurance and the patient's family income is at or below 200% of the federal poverty guidelines, the patient may be considered eligible for either a) payment plan, b) partial waiver, or c) full waiver of copayment unless the Branch Manager has reason to believe that the patient or the patient's family has sufficient available assets (not including primary residence, primary automobiles or retirement accounts) to pay the copayment amount without financial hardship.

If the patient has secondary coverage through the Medicaid program of a state where Freedom Mobility Center is not eligible to receive Medicaid reimbursement, the patient is considered not to have secondary insurance for purposes of this policy.

If the patient's family income is more than 200% of the federal poverty guidelines, the patient should be presumed not to be eligible for waiver of copayment unless the family has unreimbursed medical expenses exceeding 20% of annual family income, or unless there are other unusual circumstances that, in the judgment of the Branch Manager, cause genuine financial hardship. The Branch Manager must document the basis of that determination.

Documentation of financial hardship: It is not necessary to request documentary evidence of income and expenses in every case. However, if the Branch Manager has any doubt about the accuracy of the information provided, he or she should verify the information before approving the waiver. In some cases, it may be advisable to request copies of pay stubs, medical bills, tax returns, or other documents. The Branch Manager should document the verification process.

Communications with patients: Freedom Mobility Center will not advertise intent to waive deductibles or coinsurance for Medicare beneficiaries, or advertise intent to discount services for Medicare beneficiaries. No Freedom Mobility Center employee may tell a patient or family member that he or she does not have pay the copayment amount unless the Branch Manager has made a determination of financial need.

Collection: Except in cases where a waiver has been applied for and approved in accordance with this policy, Freedom Mobility Center will make a good-faith effort to collect deductible and copayments equivalent to the efforts the company uses to collect other debts of similar size.

Attachment B

Financial Hardship Application Guidelines

1) Patient must state income and expenses on attachment C form to document that they are at or below 200% of the current federal poverty guidelines (see “Federal Poverty Level” table below).*

2) Patient may provide other information if needed to document financial hardship. Circumstances other than standard income & expenses can indicate financial hardship. Such situations can be, but are not limited to the following:

- Proof of bankruptcy settlement
- Catastrophic situations (death or disability in family, divorce, eviction, foreclosure, disaster. etc.)
- Other documentation showing the patient would be unable to pay for medical expense and still be able to pay for other basic necessary expenses

*Additional documentation may be required if the standard income/expense information provided on *attachment B* does not meet the federal poverty guidelines as stated under #1 above. Patient will need to explain the circumstance(s) that are causing or contributing to their financial hardship. This information can be entered on *attachment C* under question # 1.

**All information relating to financial hardship requests will be kept confidential*

Attachment C

FINANCIAL HARDSHIP APPLICATION

Patient Information

First Name: ___________________________ **Last Name:** ________________________

Address: ___________________________ **Phone:** ________________________

City/State/Zip: ___________________________

Patient Income & Expenses

Income (Monthly)	Expenses (Monthly)	
Social Security: $	Rent/Mortgage: $	Medicine: $
Employment: $	Utilities: $	Insurances: $
Other: $	Food: $	Other: $
	Auto/Fuel : $	
Total Income: $		**Total Expense: $**

1. If there are any additional factors causing financial hardship, explain below:

2. Number of Dependents in Household (including self): ______________

3. Can you afford to make payments? Yes No

4. What is the minimum/maximum you can afford monthly? **Min:** _________ **Max:** __________

Patient Acknowledgement & Signature

I certify that the above amounts and calculations are correct to the best of my knowledge. I am aware of and understand that these figures will be used to support my claim of financial hardship, and that only FMC LLC will use these figures for the sole purpose of assessing financial need in accordance with it's policies and procedures.

____ ____________________________

Signature of Patient or Legal Representative: **Date:**

____

Print Name of Legal Representative:

Relationship to Patient: ☐ Self ☐ Other: ____________________________

Attachment D

California Department of Public Health

State of California Health and Human Services Agency

2019 Federal Poverty Guidelines

Persons in Family Household	Poverty Guideline	MAGI* Medi-Cal <138% Federal Poverty Level (FPL)	MAGI Household Income ≤500% FPL
1	$12,490	$17,236	$62,450
2	$16,910	$23,336	$84,550
3	$21,330	$29,435	$106,650
4	$25,750	$35,535	$128,750
5	$30,170	$41,635	$150,850
6	$34,590	$47,734	$172,950
7	$39,010	$53,834	$195,050
8	$43,430	$59,933	$217,150

For families/households with more than 8 persons, add $4,420 for each additional person.

*Modified Adjusted Gross Income