SARASOTA MEMORIAL HEALTH CARE SYSTEM POLICY

Location Attributed	Effective Date	Reviewed/ Revised Date	Policy Type
☒ **Sarasota Memorial Hospital – Sarasota**	11/18/05	10/01/24	☐ Clinical ☒ Non-Clinical
☒ **Sarasota Memorial Hospital – Venice**	11/2021	10/01/24	☐ Clinical ☒ Non-Clinical
☒ **First Physicians Group (FPG)**	11/18/05	10/01/24	☐ Clinical ☒ Non-Clinical
☒ **Sarasota Memorial Nursing and Rehabilitation Center**	11/18/05	10/01/24	☐ Clinical ☒ Non-Clinical

TITLE: CHARITY ASSISTANCE **POLICY #:** 00.FIN.51

JOB TITLE OF RESPONSIBLE OWNER: Vice President, Revenue Cycle

PURPOSE

Sarasota Memorial Health Care System (SMHCS) provides a Charity Assistance program to address the financial needs of the patients who are not eligible for other government programs and need emergent or medically necessary health services. Charity Assistance applications will be considered without regard to race, ethnicity, gender, religious preference, disability, or any other protected class. SMHCS will provide Charity Assistance to those patients who are eligible and are determined to have insufficient financial means to pay for their health care. Eligibility will be indexed to the Federal Poverty Guidelines.

POLICY STATEMENT

Sarasota Memorial Health Care System (SMHCS) Patient Assistance Program will make every reasonable attempt to provide patients with assistance through various government programs, e.g., Medicaid and Crime Victim Assistance. A patient will be considered for Charity Assistance if the patient whose family income for the 12 months preceding the determination is less than or equal to 300% of the Federal Poverty Level unless the amount of the hospital charges due from the patient exceeds 25% of the annual family income. However, in no case shall the hospital charges for a patient whose family income exceeds four (4) times the Federal Poverty Level for a family of four be considered charity. An individual's ability to pay is not represented by an income test alone. An assessment of overall net worth (e.g., real estate, checking/savings accounts, stocks, bonds, CD's, pension, trust fund) is also part of the evaluation process. An Assistance Screening Application and Charity Assistance Determination Worksheet, which includes a means/asset test, will be used to determine eligibility for charity.

Presumptive eligibility for charity may be determined through a means/asset test. This test can include factors such as qualifying for another indigent program (e.g., out-of-state Medicaid), income level, and current food stamp assistance, all evaluated through a structured application determination process.

EXCEPTIONS

Cosmetic surgery and other non-medically necessary services are exempt.

DEFINITIONS

Elective Services: Those services which are non-medically necessary or non-emergent.

PROCEDURE

1. Availability and Notification

a. Charity Assistance applications are available to anyone in need of assistance. Patients can apply for assistance in person, mail or over the phone.

b. Sarasota Memorial Health Care System shall post notices, in English and Spanish, in all Registration areas as suggested by the Florida Hospital Association and the American Hospital Association regarding the availability of Charity Assistance (see attached Financial Assistance Notice).

c. Priority consideration for Charity Assistance will be given to inpatients as well as patients requiring urgent or emergent medical care.

d. Patients requiring Charity Assistance or thought to require such will be referred to the Patient Assistance Program. These referrals will likely come from Patient Registration, Patient Financial Services, Case Managers, Patient Advocates, or the Pastoral Care Department.

e. Patients may only be approved for Charity Assistance after all other financial resources available to the patient have been exhausted. This would include, but not be limited to patient resources, private health insurance, public assistance, Medicare, Medicaid, and legal settlements. If the patient has an option for health insurance but has been unable to pay premiums due to their financial situation, Sarasota Memorial Health Care System will evaluate the option of temporarily paying for the patient's health insurance for a specified period. Note: This is normally one or two months and would not be for an extended period.

f. A patient may request consideration for Charity Assistance after all third-party coverage has been exhausted and the patient does not have sufficient income or assets to cover his or her remaining account balance.

g. If a patient has failed to contact the Patient Assistance Program at Sarasota Memorial Health Care System within 180 days from the date of their visit, the patient has surpassed the timeframe for Charity Assistance and will only be considered upon written request to the Director of Registration explaining the extenuating circumstances that prevented the patient from making contact within 180 days.

h. An individual's ability to pay is not represented by an income test alone. There is also an assessment of overall net worth (e.g.: real estate, checking/savings accounts, stocks, bonds, CD's, pensions, trust fund).

i. Determination of eligibility for Charity Assistance will cover the pending account balance at the time an application is completed and/or approved and may include all previous visits during the last 12-month period and up to 3 months into the future.

   - New financial information and an updated Assistance Screening Application with the patient's signature is required for review every 3 months after initial approval.

j. An approved Charity Assistance application does not guarantee a patient will be eligible in the future for additional assistance. The Patient Assistance Program will attempt to interview the patient or patient's family before or during each visit to determine if a patient's circumstances have changed and an updated application will be required, as well as new financial information every 90 days.

k. Charity Assistance applications will be retained by the hospital for a period of 7 years (eighty-four months) following the year in which the application was approved.

2. Application for Charity Assistance

a. When it is determined that a patient does not have insurance or the ability to pay for services, a Patient Benefits Coordinator will interview the patient or the patient's relatives/caregiver/power of attorney who are responsible for making medical decisions for the patient in compliance with HIPAA guidelines.

b. During the interview, the Patient Benefits Coordinator will gather information about the patient's circumstances and ability to pay. The Patient Benefits Coordinator will identify if there is an applicable Assistance Program for which the patient may be eligible and assist the patient or patient's family in completing the appropriate application(s) (see attached

Assistance Screening Application). The patient will be advised of all documentation required from him/her before the appropriate applications can be processed.

c. An Agency for Health Care Administration (AHCA) Income Address Certification should be completed and signed for each visit under consideration for Charity Assistance; a minimum of one every six months is required.

d. Required documentation may include, but is not limited to, third party coverage; employment status, income, family size, net worth, and proof of identity (see section 11.). The same financial guidelines will apply to all persons in determining Charity Assistance.

3. Third Party Payment - All patients will be screened for third-party sources of payment that may include, but is not limited to:

a. Personal or employer sponsored health insurance
b. Medicare, Medicaid, commercial, or any other third-party coverage
c. Liability Insurance (i.e., auto, homeowner's, worker's compensation)
d. Eligibility for public assistance programs
e. Third party coverage from a family member's employer
f. Legal settlements
g. Co-ops or organizations that share and pay for medical expenses.

4. Income/Employment Status – Income includes total cash receipts from all sources before taxes. If married, both the husband and wife's income are included. Verification of income for dependents is not required. The following is considered income, but is not limited to:

a. Wages, salaries, and compensation before deductions
b. Self-employment Total Gross Receipts
c. Social Security benefits
d. Pension and retirement benefits
e. Unemployment compensation
f. Strike benefits from union funds
g. Workers' compensation
h. Veterans' benefits
i. Public assistance payments
j. Alimony or child support
k. Military family allotments
l. Income from dividends, interest, rents, royalties
m. Income from estates and trusts
n. Regular insurance or annuity payments
o. Support from an absent family member or someone not living in the household (see attached Letter of Support)

The household income is based on last year's Tax Return and/or other proof of income for the last 12 months.

5. The following will not be considered income:

a. Food or rent in lieu of wages
b. Non-cash benefits
c. Gifts
d. Student loans and grants

6. The following may be used to prove income:

a. A tax return for the prior calendar year

b. W-2 Form, or other IRS income forms
c. Last six weeks of payroll check stubs
d. If self-employed, the Total Gross Receipts or accounting records for the last tax year
e. Other current income from retirement or disability benefits, Social Security, Veteran's Benefits or any other source of income not directly related to employment must be verified with check stubs or other documentation
f. In the absence of any of the above, a signed affidavit from the patient witnessed by a hospital representative attesting to income amounts (see attached Income Address Certification)

7. The following may be used to prove unemployment:
   a. Unemployment Compensation Program documents
   b. Most recent unemployment check stubs (a minimum of six weeks)
   c. Letters from state and local agencies on their letterhead
   d. A statement from a physician or an advanced practice professional attesting to a physical condition precluding a patient from working. It must include "From" and "To" dates.
   e. In the absence of any of the above, a signed affidavit from the patient witnessed by a hospital representative attesting to unemployment status (see attached Income Address Certification)
8. Net Worth - For an individual or family, net worth is the total value of all assets, such as a house, stocks, bonds, other securities minus all outstanding debts, such as mortgage, credit cards and revolving-credit loans. The following will be used to determine net worth, but is not limited to:
   a. Cash
   b. Checking Accounts
   c. Savings Accounts
   d. Life Insurance
   e. Stocks or Bonds
   f. Real Estate
   g. Savings Certificates
   h. Trust Fund
   i. Money held by another person in trust for the patient
   j. Retirement Investments
9. Family Size - A family is a group of two or more persons related by birth, marriage, or adoption who live together. All such related persons are considered as members of one family. Family members are defined as follows:
   a. The patient and, if married, his/her spouse
   b. Any natural, or adopted minor of the patient, or spouse who has not been removed by a court and who is not, or has ever been married
   c. Any minor for whom the patient or spouse has been given the legal responsibility by a court
   d. Any person designated as "dependent" on the patient's latest tax return
   e. Any student in the family over 18 years old dependent on the patient's family income for over 50 percent support
   f. Any other family member dependent on the patient's family income for over 50 percent support
   g. Any minor child of a minor who is solely, or partially, supported by the minor who is a member of the patient's family.
10. Dependency is determined by one of the following documents that contain the adult or spouse's name:
    a. Court-ordered guardian/conservator ship

b. Current tax return
c. Birth certificate
d. Baptismal record
e. Social Security award letter
f. U.S. Immigration documentation
g. In the absence of any of the above documents, a signed affidavit from the parents, attesting to the dependency and witnessed by the hospital representative will be required.
h. A minor is defined as not having reached his/her eighteenth (18^{th}) birthday and neither is, nor has been married. When the marital status of the minor cannot be determined, or when there is no documentation indicating the patient is an emancipated minor, the parents or legal guardian should be designated as the responsible party. The parents or guardian's income and assets should be used to determine eligibility for Charity Assistance. Generally, the patient's declaration of family size is accepted if it is consistent with the other documentation provided, except in those instances where the number of dependents and/or age of dependents do not appear reasonable.

11. Proof of Identity - The following may be used to establish the identity of the patient or responsible person:
    a. Driver's License
    b. Birth Certificate and a picture identification
    c. Referral letters from state or local agencies on agency letterhead and a picture identification
    d. Social Security card and a picture identification
    e. Department of Public Safety identification card
    f. Other to include passport, a picture student identification, employee identification card, immigration documentation, etc. including a picture identification.
12. Special Circumstances/Other Applicant Categories - There may be certain circumstances or conditions that may also arise in which certain individuals may be eligible to receive Charity Assistance for their bill. Some of these circumstances are as follows:
    a. Homeless Persons – A homeless person is defined as an individual who has no home or haven and depends on charity or public assistance. Such individuals will generally be eligible, even if they are unable to provide all of the documentation required for the Charity Assistance application.
    b. Deceased Patients - A patient who has expired may still be considered for Charity Assistance. If the deceased patient has no estate, then his or her income will be deemed as zero for the purposes of the Charity Assistance application.
    c. Medicaid Patients - If a patient qualifies for Medicaid, he/she will be considered eligible for Charity Assistance to cover remaining balances if annual Medicaid benefits are exhausted.
    d. Undocumented Resident – Individuals who are unable to provide appropriate documentation to prove United States citizenship, Permanent Residency or valid Visa status may be eligible for Charity Assistance in some instances.
    e. Other – Patients designated as Jane or John Doe at the time of admission because their true identity was/is unknown, and they meet Charity Assistance guidelines.
13. Determination of Eligibility
    a. If a patient does not have Medicaid, but would qualify, he/she must cooperate with that application process. Only if the Medicaid application is denied or the patient is deemed ineligible may the patient be considered for Charity Assistance.
    b. Individuals who qualify for Medicaid but have service dates prior to the effective date will qualify automatically for Charity Assistance for services that occurred no more than twelve (12) months prior to being eligible for Medicaid. An Assistance Screening Application will be

required along with the appropriate documentation of income and assets, as well as proof of Medicaid eligibility.

c. If a patient would qualify for Crime Victim's Compensation, he/she must cooperate with the application process and authorize release of funds to SMHCS. Only if the application is denied or the patient is deemed ineligible may the patient be considered for Charity Assistance.

d. Only patient balances will be considered for Charity Assistance. The patient's balance is considered that amount for which there is no third-party coverage, and no other funding is available.

e. If the patient's family income and/or net worth is less than or equal to the Hospital's Charity Assistance eligibility limit for that family size, the patient may be considered eligible for Charity Assistance equaling 100% of the patient's balance. The Hospital's eligibility limits will be indexed to the current federal poverty guidelines and includes an asset test (see Charity Assistance Determination Worksheet and Assistance Screening Application).

f. If a patient does not qualify under the Hospital's Charity Assistance guidelines, then the patient may be eligible for the Hospital's Financial Assistance program.

g. If a patient's income changes significantly, supporting documentation may be submitted for re-evaluation of Charity Assistance. Any payments made to date will be counted toward the amount due and will not be refunded.

14. Approval and Notification

All the required documentation for Charity Assistance determination greater than $20,000 must be reviewed and approved by either the Director of Registration or the Director of Patient Financial Services.

a. Completed Assistance Screening Application, Charity Assistance Determination Worksheet and all supporting documentation shall be forwarded to the Director of Registration or the Director of Patient Financial Services after the Patient Benefits Coordinator has completed the application and the appropriate Supervisor/Manager has reviewed and approved the application.

b. Any missing documentation for the Assistance Screening Application must be supplied within seven to ten days from the date of the request for documents. There may be an extension of this time frame under special circumstances (i.e. patient was in the hospital for additional days after being advised of the documents needed).

c. Once complete, the file will be reviewed against the hospital's eligibility criteria. If the patient meets criteria, the Manager of Medicaid and Disability will approve Charity Assistance for accounts with a balance of $20,000 or less. Accounts with a balance of $20,001 or more must be approved by the Director of Registration. Accounts with a balance between $60,000 and $100,000 will require an additional approval by the Director of Patient Financial Services. Accounts with a balance of $100,001 or more will require an additional approval by the Vice President of Revenue Cycle.

d. Once approved or denied, the Patient Benefits Coordinator will send a Charity Assistance Outcome Determination letter to the patient. (See Charity Assistance Outcome Determination letter samples).

e. The Patient Benefits Coordinator will also document the patient account regarding the outcome of the Charity Assistance application.

f. As will be indicated in the Charity Assistance Outcome Determination letter sent to the patient, any applicant wishing to appeal a denial, may do so by writing to the Director of Patient Registration with support and reason for reconsideration.

g. In the event that assets or payment become available, Sarasota Memorial Health Care System reserves the right to reverse the approved charity application. This could be through

the identification of Medicaid eligibility, liability settlements, insurance obtained, etc. after the account has been written off to Charity.

15. Insurance/Financial Classification
    a. When a Charity Assistance Application and all supporting documentation have been received and are under review, the Financial Class will be changed to Pending Financial Assistance; until that time the patient may receive calls from the hospital's contracted vendors in an attempt to collect the balance owed for services rendered.
    b. Once approved, Charity will be loaded as the Insurance/Payer and the Financial Class will be changed from Pending Financial Assistance to SMHCS Agency.
    c. The appropriate Charity Assistance adjustments will be made to the patient account in the Allscripts AM/PFM system using one of the following designated codes:
        1) *9906001 - Charity Assistance, Sarasota County Resident*
        2) *9906003 - Unpaid Out of State Medicaid Claim*
16. Changes to the Policy or Eligibility Criteria

    The eligibility criteria should be reviewed as necessary by the Director of Registration and Director of Patient Financial Services but updated annually to reflect published changes in the federal poverty guidelines. Revisions may be made at any time to the criteria or the policy based on changes in the hospital's financial ability to provide Charity Assistance or changes in state or federal regulations.

RESPONSIBILITY

It is the responsibility of the Patient Registration and Patient Financial Services Department to adhere to this policy. It is the responsibility of the Director of Patient Registration, the Manager of Medicaid and Disability, the Director of Patient Financial Services, and the Vice President of Revenue Cycle to ensure that accounts written off to charity have the appropriate income and/or net worth documentation.

REFERENCES

Florida Statute 409.911(1)(c) – "Charity Care" or "Uncompensated Charity Care"
www.smh.com/Home/Patients-Visitors/Financial-Assistance
42 U.S.C. 1320a-7b, 42 U.S.C. 1320a-7d, 42 U.S.C. 1302, 42 U.S.C. 1320a-7a

AUTHOR(S)

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ATTACHMENT(S)

Charity/Financial Assistance Determination Worksheet
Assistance Screening Application
Required Documentation
Income Address Verification
Letter of Support
Charity Assistance Outcome Determination Letters (examples)
Financial Assistance Notice

APPROVALS:

Approval of the new or reviewed/revised policy.		
Committees/Sections/Departments:		**Date**
Director/Responsible Owner:	Robb Wilburn, Director, Patient Registration	09/25/24
Vice President/Executive Director:	JR Edmiston, Vice President, Revenue Cycle	09/25/24
Chief Financial Officer:	Jeff Limbocker, Chief Financial Officer	09/25/24
Chief of Staff: **(if clinical policy or appropriate)**		N/A
Medical Executive Committee: ***(if clinical and review requested by CMO and COS)***		N/A
Chief Executive Officer:	David Verinder, Chief Executive Officer	09/25/24

SARASOTA MEMORIAL HEALTH CARE SYSTEM

Sarasota Memorial Health Care System
Charity/Financial Assistance (F/A)
Determination Worksheet

Adjustment Date: _____

Patient Name:

Account Number(s):

A	Family Income (Last 12 Months)		
B	Family Size		
C	Self Pay Portion		(estimate or actual)
D	Self Pay as % of Family Income	0.0%	
E	Family income as % of FPG	0.0%	
F	Is line [D] greater than 25%	NO	Yes = Charity (No - go to line G)
G	Is line [E] less than or equal to 300%	YES	Yes = Charity (No - go to line H)
H	Is line [E] between 301% and 350%	NO	Yes = F/A - up to 80% discount (No - go to line I)
I	Is line [E] between 351% and 400%	NO	Yes = F/A - up to 70% discount (No - go to line J)
J	Is line [E] is greater than 400%	NO	Yes = F/A - up to 60% discount

Federal Poverty Guideline 0%						
# Persons	**2024 FPG**		**300%**		**350%**	**400%**
1	15,060		45,180		52,710	60,240
2	20,440		61,320		71,540	81,760
3	25,820		77,460		90,370	103,280
4	31,200		93,600		109,200	124,800
5	36,580		109,740		128,030	146,320
6	41,960		125,880		146,860	167,840
7	47,340		142,020		165,690	189,360
8	52,720		158,160		184,520	210,880
each addle	5,380					

Application completed by:
(required) Date:

Manager/Supervisor reviewed by:
(required) Approved/Denied Date:

Director Patient Registration
(required for accounts over $20,000) Date:

Director Patient Financial Services
(required for accounts over $60,000 or greater) Date:

Vice President, Revenue Cycle:
(required for accounts $100,001 or greater) Date:

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HEALTH CARE SYSTEM

FOR OFFICE USE ONLY
CW _____ REP __ _
TYPE _____ __

ASSISTANCE SCREENING APPLICATION

In order for us to assist you financially, it is important that you provide us with the following information regarding your income and assets. This questionnaire is designed to assess your needs and remains confidential. If you have any questions with this form, please contact the Patient Assistance Program at 941-917-7459. You will be prompted to leave a message and someone will return your call within two business days.

PATIENT NAME: _____ **DATE:** _____

RESPONSIBLE PARTY: _____ **ACCOUNT#:** _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

Street Address: _____ City, State, Zip: _____

Telephone Number: _____ Other Contact #s: _____

Marital Status: **D** Single D Married D Divorced D Together; if Divorced/Separated/Widowed, for how long? _____

Age: _____ Patient's Maiden Name, if applicable: _____

1. Are you currently paying for any health insurance coverage? ..... **D**Yes D No
   If yes,$_____ pemronth Begin Date: _____
2. When was the last time you had health insurance?
3. Have you ever applied for Social Security Disability? D Yes **D** No If yes, when? _____
   What was the outcome? _____
4. Have you ever applied for Medicaid? D Yes D No If so, when? _____
5. Purpose of Current Visit: _____
   Was injury due to a crime? ..... **D**Yes D No
   Was injury due to an auto accident? ..... **D**Yes D No
   Did injury happen at work or at home? ..... DYes D No
6. Do you have other Health Issues? D Yes D No If yes, please list: _____
7. Has your health condition (current and/or previous) caused you to be unable to work? **D** Yes D No How long? ___ _
8. Has the doctor advised you of your recovery time? _____
9. Do you expect to be able to go back to work within the next 12 months? ..... **D** Yes D No
10. Are you Pregnant? D Yes D No Due Date: _____
11. What is the total number of members in your immediate family?

	Name	Relationship	Date of Birth	Social Security Number
Patient				
Spouse				
Child				
Child				
Child				
Child				
Child				
Other				
Other				

12. Is anyone in the family currently employed or has been employed in the last 12 months? . . . . . 0 Yes O No

	Current Employers	Gross (mo, bi/mo, wk,bi/wk)	Net (mo, bi/mo, wk, bi/wk)	Dates of Employment
Patient				
Spouse				
Other				

13. If Unemployed: How long? _____ Related to health condition? 0 Yes O No
Receiving Unemployment Compensation? 0 Yes O No $_____

14. Do you or a household family member receive any other income listed below? 0 Yes O No

Type of Income	Check One	Amount
Social Security	0 Yes O No	$_____
Veteran's Benefits	0 Yes O No	$_____
Self-Employment Income	0 Yes O No	$_____
Retirement/Pension Benefits	☐Yes O No	$_____
Worker's Compensation	☐Yes O No	$_____
Child Support or Alimony	☐Yes O No	$_____
Public Assistance Payments	☐Yes O No	$_____
Support from Relatives or Friends	☐Yes O No	$_____
Income from Rent	☐Yes O No	$_____
Income from Dividends, Interest Royalties	☐Yes O No	$_____
Railroad Benefits	☐Yes O No	$_____
Military Family Allotments	0 Yes O No	$_____
Income from Estates and Trusts	0 Yes O No	$_____
Regular Insurance or Annuity Payments	☐Yes O No	$_____
Crops or Other Farm Income	0 Yes D No	$_____
Other:_____	0 Yes O No	$_____

15. If you have no source or income, who is supporting you? _____

16. Do you pay Rent? ☐Yes O No How Much? _____
Do you pay a Mortgage? 0 Yes 0 No How Much? _____

17. How do you pay your bills? _____

18. Do you or any household family member have any assets listed below:

Assets	Yes / No	
Cash	O Yes O No	$_____
Credit Cards	☐Yes ☐No	$_____
Source of Available Credit	☐Yes ☐No	$_____
Checking Accounts	☐Yes ☐No	$_____
Savings Accounts	☐Yes ☐No	$_____
Life Insurance	☐Yes ☐No	$_____
Stocks or Bonds	☐Yes ☐No	$_____
Real Estate	☐Yes ☐No	$_____
Savings Certificate	☐Yes ☐No	$_____
Trust Fund	☐Yes ☐No	$_____
Retirement Accounts	☐Yes ☐No	$_____
Money held by another person or Nursing home	0 Yes ☐No	$_____

19. Does any household family member have one or more vehicles, motorcycle or recreational vehicles? If yes, please list below.

Name or Owner	Year & Model	Amount Owed	Re-Sale Value

20. Did you file taxes last year?..... 0Yes O No

21. Legal Status: 0 U.S. Citizen O Perm. Resident O Sponsored O Visa (work, student, visitor) 0 Other: _____
Country of Birth: _____ Date of U.S. Entry: _____

22. Is there someone else with whom we can discuss your financial situation regarding payment of your bill? ... 0 Yes O No
Name: _____ Relationship: _____

COMMENTS: (PLEASE PROVIDE ANY ADDITIONAL INFORMATION OR COMMENTS REGARDING YOUR FINANCIAL SITUATION)

I understand that my case record is confidential and no information will be released from it unless properly authorized by me.

I, certify that I have or had read to me all the statements on this form and that the information given is true and complete to the best of my knowledge. I understand that if I have deliberately given any false information or have withheld any on information regarding any situation, I am subject to possible prosecution for fraud. By signing this application, I am authorizing the release of any information needed to determine my eligibility, not to exclude address verification, a credit check through national credit bureau, an asset check through the County Tax Assessor, and verification of all benefits listed.

Patient Signature	Date
Signature of Responsible/Authorized Person/Title or Relationship	Date
Address of Responsible Person or Authorized Person	Date
Witness Signature	Date
Hospital Representative Signature	Date

SARASOTA MEMORIAL HEALTH CARE SYSTEM

REQUIRED DOCUMENTATION

Date: _____

Dear Patient:
In order for Sarasota Memorial Health Care System to complete your application based assistance, the following documents must be returned to your Patient Benefits Coordinator at Sarasota Memorial Health Care System, 1700 S. Tamiami Trail, Sarasota, FL 34239-3555. A return envelope is attached (unless downloaded from our SMHCS web-site).

The following is a list of documents that we will need. Send only what applies to your case.

Income
( ) Last six weeks of pay-check stubs prior to date of service; could require multiple months if more than one date of service
( ) Proof of any other income:
- ( ) Social Security benefits
- ( ) Pension and retirement benefits
- ( ) Unemployment compensation
- ( ) Strike benefits from union funds
- ( ) Workers' compensation
- ( ) Veterans' benefits
- ( ) Public assistance payments
- ( ) Alimony or child support
- ( ) Military family allotments
- ( ) Income from dividends, interest, rents, royalties
- ( ) Income from estates and trusts
- ( ) Regular insurance or annuity payments
- ( ) Support from an absent family member or someone not living in the household
- ( ) Other

( ) W-2 for the prior calendar year
( ) Most current Tax Return, all pages
( ) If Self-Employed, total gross receipts or last year of accounting records

Assets
( ) Checking account statement(s), all pages (last 3 months)
( ) Savings account statement(s), all pages (last 3 months)
( ) Proof of stocks or bonds, savings certificate, IRA, trust fund or any other asset

Please return documents within 7-10 days of discharge.
COPIES ONLY
1700 S. Tamiami Trail * Sarasota, FL * 34239-3555
(941) 917-8080

This document is required for reporting the household income of patients at Sarasota Memorial Health Care System to the Agency for Health Care Administration.

INCOME ADDRESS CERTIFICATION

I,_____, residing in _____ County at _____certify that my family income for the past 12 months has been

$ _____ and there are ____ people in my family.

Check how the earnings are calculated: ___ hourly, ___ weekly, ___ monthly. The total family income for the 4 weeks prior to admission is $_____. The number of weeks worked during the past 12 months is _____. The income information can be verified by calling the following employer(s):

_____

Company Phone Company Phone

Are there any minor children living at home?.....( ) Yes ( ) No

Is anyone in the household currently pregnant or has had a child in the past three (3) months?.....( ) Yes ( ) No

Does anyone in the household have a doctor certified disability expected to last twelve (12) months or more?.....( ) Yes ( ) No

I hereby certify that the above information is true. Sarasota Memorial Health Care System is authorized to contact employers, creditors, disability or welfare sources to confirm the above information. This also includes the rights of examination of my credit bureau file. It is the responsibility of Sarasota Memorial Health Care System to regard this information as confidential. In accordance with Florida Statues 817.50, providing false information to defraud a hospital for the purpose of obtaining goods or services is a misdemeanor in the second degree.

_____ _____

Guarantor Date Witness Date

LETTER OF SUPPORT

Date:

I_____am allowing_____
Name of Supporter **Name of Recipient**

to stay at my residence located at: _____
Address **City** **State**

at no charge.

and/or

I_____am paying the following expenses for
Name of Supporter

_____.
Name of Recipient

Complete as applicable:

Expense		$ Amount		Expense		$ Amount		Expense		$ Amount
Rent	Yes / No			Food	Yes / No			Car Pymt	Yes / No	
Utilities	Yes / No			Phone	Yes / No			Car Ins	Yes / No	
Other	Yes / No									

___The money is given to the individual to pay their own expenses.

___Expenses are being paid directly to_____.

I certify that the above information is true and correct to the best of my knowledge.

I can be reached at_____to verify this information.
Phone Number

_____ _____
Signature **Date**

Charity Assistance Outcome Determination - Approved

Date:

Patient Name:
Account Number(s):
Service Date:

Dear Patient,

This letter is notification that Charity Assistance has been approved for the account(s) listed on this letter. The account(s) is now considered closed.

If you have any questions or concerns, please contact me at the number listed below.

Thank you for choosing Sarasota Memorial Health Care System for your health care needs.

Sincerely,

Patient Benefits Coordinator
(941) 917-8080

Charity Assistance Outcome Determination Denied – Federal Poverty Guidelines/Net Worth

Date:

Patient Name:
Account Number(s):
Service Date:

Dear Patient,

This letter is notification that your request for Charity Assistance has been denied because your income exceeds Federal Poverty Guidelines for Charity Assistance or your net worth exceeds Hospital guidelines.

If you wish to appeal this determination, a written letter of appeal including the reason you wish to have your application reconsidered should be mailed to the Vice President, Revenue Cycle.

Thank you for choosing Sarasota Memorial Health Care System for your health care needs. If you have any questions or concerns, please contact me at the number listed below.

Sincerely,

Patient Benefits Coordinator
(941) 917-8080

SARASOTA MEMORIAL
HEALTH CARE SYSTEM

FINANCIAL ASSISTANCE POLICY SUMMARY

At Sarasota Memorial Health Care System, we are dedicated to meeting the healthcare needs of our community. Emergency medical care is provided to everyone, regardless of the ability to pay or lack of insurance.

Sarasota Memorial Health Care System offers financial assistance to eligible patients who are uninsured, underinsured, ineligible for a government health care program, or who are otherwise unable to pay for medically necessary care based on their individual financial situation. Patients seeking financial assistance must apply for the program. You can get an application and the full Financial Assistance Policy by visiting our website at www.smh.com/Home/Patients-Visitors/Financial-Assistance, or by calling (941) 917-8080. We may use your application to determine available health insurance including disability or Medicaid. It is important for the hospital and patient to work collaboratively to address payment concerns.

Once we review your completed Financial Assistance Application, your obligations to us will endif your annual household income is less than 200% of the current federal poverty level. This does not include cosmetic procedures and self-pay pricing packages.

SARASOTA MEMORIAL
HEALTH CARE SYSTEM

RESUMEN DE LA NORMA DE AYUDA ECONOMICA

En el Sistema de Salud de Sarasota Memorial estamos dedicados a satisfacer las necesidades de atenci6n de salud de nuestra comunidad. Se presta atenci6n medica de urgencia a todo el mundo, independientemente de su capacidad de pagar ode la carencia de seguro.

Pagar las facturas medicas puede resultar dificil. Si usted no esta en condiciones de pagar las suyas, puede solicitar ayuda econ6mica rellenando el formulario con todos los datos requeridos. Usted puede obtener una solicitud y la Norma de Ayuda Econ6mica completa en ingles o en espariol si acude al Hospital principal, si busca en Ifnea en www.smh.com/Home/Patients-Visitors/Financial-Assistance, o llamando al (941) 917-8080. Podemos emplear su solicitud para determinar el seguro de salud disponible entre ellos Medicaid o por discapacidad. Resulta importante que el hospital y el paciente trabajen en colaboraci6n para tratar las cuestiones de los pagos.

Una vez que revisemos su Solicitud de Ayuda Econ6mica ya rellenada, sus obligaciones con nosotros terminaran si los ingresos anuales de su nucleo familiar son menores del 200% del nivel de pobreza federal actual. Esto no incluye los procedimientos esteticos ni los paquetes de precios que corren por cuenta propia.