SARASOTA MEMORIAL HEALTH CARE SYSTEM POLICY

Location Attributed	Effective Date	Reviewed/ Revised Date	Policy Type
☒ **Sarasota Memorial Hospital – Sarasota**	11/2/05	10/01/24	☐ Clinical ☒ Non-Clinical
☒ **Sarasota Memorial Hospital – Venice**	11/2021	10/01/24	☐ Clinical ☒ Non-Clinical
☒ **First Physicians Group (FPG)**	11/2/05	10/01/24	☐ Clinical ☒ Non-Clinical
☒ **Sarasota Memorial Nursing and Rehabilitation Center**	11/2/05	10/01/24	☐ Clinical ☒ Non-Clinical

TITLE: FINANCIAL ASSISTANCE **POLICY #:** 00.FIN.52

PAGE: 1 of 21

JOB TITLE OF RESPONSIBLE OWNER: Vice President, Revenue Cycle Management

PURPOSE

Sarasota Memorial Health Care System (SMHCS) provides a Financial Assistance program to support the financial needs of all patients. This program is aimed at individuals who need urgent or essential medical services. Applications for Financial Assistance are evaluated without regard to race, ethnicity, , gender, religious preference, disability, or any other protected class.

Discounts are generally not available for patients with Federal Health plans, though in some cases, a discount may be granted based on financial need. Discounts are determined according to a sliding fee schedule based on family income, assets, and the number of dependents.

POLICY STATEMENT

Sarasota Memorial Health Care System (SMHCS) Patient Assistance Program will make every reasonable attempt to provide patients with Financial Assistance through government programs. Patients that do not qualify for government assistance for hospital-based services will be assessed based on the Federal Poverty Guidelines. An individual's ability to pay will include an assessment of overall net worth (e.g., income, checking/savings, real estate, stocks, bonds, CD's, pension, trust fund).

a. Patients whose family income is between 301% and 350% of the Federal Poverty Guideline may be eligible for up to an 80% discount off total charges.
b. Patients whose family income is between 351% and 400% of the Federal Poverty Guideline may be eligible for up to a 70% discount off total charges.
c. Patients with a family income greater than 400% of the Federal Poverty Guideline may be eligible for up to a 60% prompt payment discount. To receive the prompt payment discount, full payment must be made within 30 days of discharge.

<u>Inpatient Rehabilitation Facility (IRF) Services</u>

a. Patients whose family income is between 301% and 350% of the Federal Poverty Guideline may be eligible for $915 per day; $6,405 per week.
b. Patients whose family income is between 351% and 400% of the Federal Poverty Guideline may be eligible for $1,200 per day; $8,400 per week.
c. Patients whose family income is greater than 400% of the Federal Poverty Guideline may be eligible for $2,500 per day; $17,500 per week.

EXCEPTIONS

A patient must be prequalified for elective services.

DEFINITIONS

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

PROCEDURE

1. Availability and Notification

    a. Financial Assistance applications are available to anyone in need of assistance. Patients can apply for assistance in person, mail, email 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 Financial Assistance (see attached Financial Assistance Notice).
    c. For inpatient and outpatient services that are not urgent or emergent, prior approval must be obtained for Financial Assistance. A patient must be prequalified for elective services.
    d. Prequalification for elective services requires completing the Assistance Screening Application and providing required income and asset documentation prior to the procedure. This may also include paying a portion of the estimated charges.
    e. Patients may only be approved for Financial 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 the 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 to two months and would not be for an extended period.
    f. 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 Financial Assistance and will only be considered if a letter is written to the Director of Registration explaining the extenuating circumstances that prevented the patient from making contact within 180 days.
    g. 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).
    h. Determination of eligibility for Financial 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.

    i. An approved Financial 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.
    j. Financial 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 Financial Assistance

    a. When it is determined that a patient does not have funding from a third-party payer and is unable to pay at the time of service, a Patient Benefits Coordinator will interview the patient

or the patient's relatives/caregiver/power of attorney 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. 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 Financial 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 the amount of Financial 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 compensations 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, 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 Verification).

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. United States Immigration documentation
g. In the absence of any of the above documents, a signed affidavit from the patients, attesting to the dependency and witnessed by a 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 Financial 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 – The following may also be considered for Financial Assistance:

a. Undocumented Residents – Individuals who are unable to provide appropriate documentation to prove United States citizenship, Permanent Residency, or valid Visa status.
b. Other – Patients designated as Jane or John Doe at the time of admission because their true identity was/is unknown, and they meet Financial Assistance guidelines.

13. Determination of Eligibility

a. The discount authorization process will be as follows:

1) For consideration of a discount the Patient Benefits Coordinator will complete an Assistance Screening Application and a Financial Assistance Determination Worksheet on behalf of the patient and/or guarantor and request supporting documentation as necessary.
2) If the patient's family income and/or net worth is less than or equal to the Hospital's Financial Assistance eligibility limit for that family size, the patient may be considered eligible for Financial Assistance based on a sliding scale. The Hospital's eligibility limits will be indexed to the current federal poverty guidelines and includes an asset test (see

attached Assistance Screening Application and Financial Assistance Determination Worksheet).

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

b. If the patient meets the guidelines for the program, the Patient Benefits Coordinator will collect the full discounted charges. If the patient is unable to pay in full, the Patient Benefits Coordinator will set up a monthly payment plan based on the amount of the charges; the general guideline is up to 12 months.
   1) If prior to services rendered - a discount is based on the estimated charges due. If complications arise, the discounted amount will be reviewed against final charges.
   2) After services are rendered - the discount will be based on the final charges.

14. Approval and Notification

All the required documentation for Financial 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, Financial 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 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 Financial 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. Once approved or denied, the Patient Benefits Coordinator will send a Financial Assistance Outcome Determination letter to the patient. (See Financial Assistance Outcome Determination letter samples).
d. The Patient Benefits Coordinator will also document the patient account regarding the outcome of the Financial Assistance application.
e. As will be indicated in the Financial 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.
f. If assets or payment become available, Sarasota Memorial Health Care System reserves the right to reverse the approved Financial Assistance Application. This could be through the identification of Medicaid eligibility, liability settlements, insurance obtained, etc. after the account has been written off to Financial Assistance.

15. Insurance /Financial Classification

a. When a Financial Assistance Application and all supporting documentation has been received and is 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, the appropriate payment due by the patient will be entered in the Hospital's system and the Financial Class will be changed from Pending Financial Assistance to SMH

Agency. The account balance will be changed to reflect the payment due based on the Financial Assistance approval and the patient will receive a statement balance based on that amount. If a budget plan has been approved, the statement balance will be generated monthly until the discounted amount has been collected. If the patient defaults on the agreed upon discounted amount one month, the discounted adjustment will be reversed, and the patient will be responsible for the full balance minus any previous payments. The Financial Class will be removed from SMH Agency and the account will follow the appropriate process with the Hospital's collection agencies.

c. The appropriate adjustments will be made to the patient account in the Allscripts AM/PFM system using one of the following designated codes:

    1) 9900300 - Financial Assistance, Sarasota County Resident
    2) 9900302 - Financial Assistance, Sarasota County Non-Resident

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 and should be 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 Financial Assistance or changes in state and federal regulations.

17. Other Adjustments and Discounts

For those patients that may belong to an out-of-network plan, be inadequately insured or be uninsured but fail to qualify for financial or charity assistance may be eligible for other discounts or adjustments.

a. If a patient is uninsured or underinsured (e.g., limited benefit plan, exhausted benefits, deductible greater than $10,000 etc.) and does not qualify for any other financial or charitable assistance they may be eligible for a discount up to sixty percent (60%) of the total charges.
b. If a patient is a member of an out-of-network plan and is a documented resident of the United States, they may be eligible for a discount up to forty percent (40%) of the total charges.
c. If a patient utilizes a wrap network, foreign travel insurance, foreign insurance, medi-share type of network, or other similar type of organization that reimburses providers for patient's medical care, those accounts may be eligible for a discount up to twenty percent (20%) of total charges.

These discounts and adjustments do not apply to any account that is the result of an accident, liability claim, or other actions that result in a legal settlement.

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 financial assistance have the appropriate income and/or net worth documentation.

REFERENCES

www.smh.com/Home/Patients-Visitors/Financial-Assistace
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)

JR Edmiston, Vice President, Revenue Cycle

REVIEWING AUTHOR(S)

JR Edmiston
Robb Wilburn
Judith Sewell

ATTACHMENT(S)

Charity/Financial Assistance Determination Worksheet
Assistance Screening Application
Required Documentation
Income Address Certification
Letter Of Support
Financial 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	09/23/24
Vice President/Executive Director:	JR Edmiston, Vice President, Revenue Cycle	09/23/24
Chief Financial Officer:	Jeff Limbocker, CFO	
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, CEO	09/23/24

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	5,140					

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:

S.\R...\S()'l \
.\IE.\IORL\L
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? . . . . . DYes D No
   Was injury due to an auto accident? . . . . . DYes 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. .D y Oeuxpect to be able to go back to work within the next 12 months? . . . . . DYes 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? ..... DYes ☐ No

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

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

14. Do you or a household family member receive any other income listed below? ☐Yes **D** No

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

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

16. Do you pay Rent? ☐Yes **D** No How Much? _____
Do you pay a Mortgage? ☐Yes ☐ 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	Value
Cash	D Yes **D** No	$_____
Credit Cards	☐Yes ☐ No	$_____
Source of Available Credit	☐Yes ☐ No	$_____
Checking Accounts	☐Yes ☐ No	$_____
Savings Accounts	☐Yes **D** No	$_____
Life Insurance	☐Yes **D** No	$_____
Stocks or Bonds	☐Yes ☐ No	$_____
Real Estate	☐Yes ☐ No	$_____
Savings Certificate	☐Yes ☐ No	$_____
Trust Fund	☐Yes **D** No	$_____
Retirement Accounts	☐Yes ☐ No	$_____
Money held by another person or Nursing home	☐Yes **D** 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? ..... DYes ☐ No

21. Legal Status: ☐ U.S. Citizen D Perm. Resident ☐ Sponsored ☐ Visa (work, student, visitor) D 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? ... D Yes **D** 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

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 SMH 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) 917-7459

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**

Financial Assistance Outcome Determination - Approved

Date:

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

Dear Patient,

This letter is being sent as notification that a Financial Assistance discount has been applied to the account(s) referenced above. The remaining balance of $_____ is due now. Payment may be made by check, money order or credit card. If you are paying by check, please include your account number(s) on the check.

If payment has been made since the date of this letter, please disregard this request. 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

Credit Card Authorization
When paying by credit card, check the appropriate card and complete the information below or call the cashier at (941) 917-2237 to pay by phone.

[ ] Visa [ ] MasterCard [ ] Discover [ ] American Express

Card Number:_____
Expiration Date: _____
Signature of Cardholder: _____
Payment: $_____

Budget Letter & Financial Assistance

Date:

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

Dear Patient,

As agreed, you are responsible to make monthly payments of $_____ for _____ months; the total amount to be paid is $_____. Once you have fulfilled this amount, the remaining balance is approved for Financial Assistance and your account will be closed at that time.

If you default on your payment for a month, the Financial Assistance discount will be reversed and you will be responsible for the original full balance minus any payments already applied to your account.

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

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

Date:

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

Dear Patient,

This letter is being sent as notification that your request for Financial Assistance has been denied because your income exceeds Federal Poverty Guidelines for Financial 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.