Request for Reduction of a Patient Responsibility Payment

The patient will need to complete a financial disclosure form (see attachment B) and provide documentation of proof of income. Appropriate documentation of financial hardship would be one or more of the following:

1) Documented proof that patient is at or below 200% of the current federal poverty guidelines (see attachment B for 2008 guidelines). This can include documents such as

    a. W-2 withholding statements
    b. Pay check stubs
    c. Income tax return
    d. Forms from Medicaid or other State-funded medical assistance
    e. Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

    a. proof of bankruptcy settlement
    b. catastrophic situations (death or disability in family, divorce)
    c. or other documentation that shows that patient would be unable to pay medical bill and still be able to pay for other basic necessary expenses.

Income shall be annualized from the date of request based on documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Any denial of “financial hardship” discount request will be written and will include instructions for reconsideration. If additional documentation of financial need is received to support charity care, the request will be reviewed and considered per the above guidelines.

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

OIG Special Fraud Alert (1994). OIG Advisory Opinion 97-4. Federal Register, Vol 65, No. 81, 4-26-00 pages 24401-2440742 CFR, section 1001.952 (k)HIPAA, section 231(h), section 1128A42 USC, Section 1320a-7aBBA, section 4331 False Claims Act, Public Law 104-191, Kennedy v Connecticut General Life Ins. Co (Case Law) 924 F.2d 698 (7th Cir. 1991) Managed Care Contracts

ActivePT
Specialized Physical Therapy

Financial Hardship Discount Information Needed

200% of (or 2 times) 2008 HHS Poverty Guidelines-Used to determine financial hardship based on income.

2008 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,400	$13,000	$11,960
2	14,000	17,500	16,100
3	17,600	22,000	20,240
4	21,200	26,500	24,380
5	24,800	31,000	28,520
6	28,400	35,500	32,660
7	32,000	40,000	36,800
8	35,600	44,500	40,940
For each additional person, add	3,600	4,500	4,140

SOURCE: *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971–3972

Please provide following information so we may complete your application:

- ❑ MOST RECENT IRS TAX FORMS (1040 AND/OR W-2) (MUST BE SIGNED)
- ❑ CHECK STUBS FOR THE PAST 30 DAYS FOR ALL PERSONS EMPLOYED IN THE HOME.
- ❑ UNEMPLOYMENT CHECK STUBS FOR THE PAST 30 DAYS.
- ❑ DRIVERS LICENSE OR IDENTIFICATION CARD FOR ADULTS.
- ❑ PROOF OF ALL OTHER INCOME RECEIVED IN THE PAST 30 DAYS.
- ❑ PROOF OF ALL OUTSTANDING BILLS (PAYMENT STUBS, CANCELLED CHECKS, ETC.)
- ❑ DSHS DENIAL LETTER.
- ❑ MEDICAID FORMS OR CARD
- ❑ ATTACHED FINANCIAL STATEMENT (COMPLETELY FILLED OUT AND SIGNED)

PLEASE BE SURE TO **SIGN** THE ATTACHED FINANCIAL STATEMENT. YOUR REQUEST WILL NOT BE PROCESSED IF THIS IS NOT SIGNED.

PLEASE RETURN ALL ITEMS (AS APPLICABLE) ON THIS CHECKLIST (IN PERSON OR BY MAIL)
FINANCIAL STATEMENT PAYMENT PLAN/UNCOMPENSATED SERVICES APPLICATION

PATIENT NAME: ______________________________

DATE(S) OF SERVICE: ____

NAME OF RESPONSIBLE PARTY:____

RELATIONSHIP TO PATIENT:_____________________________ SPOUSE: _______________________________________

TELEPHONE: _________________________ ADDRESS:____

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):________

EMPLOYER:_________________________________ ADDRESS:____

IF UNEMPLOYED, HOW LONG?:_______________________

SPOUSE'S EMPLOYER:_____________________________ ADDRESS:____

IF UNEMPLOYED, HOW LONG?:____________________________

OTHER FAMILY MEMBER'S EMPLOYER(S): (INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS)
____

____

____

MONTHLY FAMILY INCOME & SOURCE

__Patient __Spouse __Responsible Party __Children Working

Monthly Salary (Gross) $________ Public Assistance Benefits $_______ Unemployment Benefits $_______

Social Security Benefits $_______ Workman's Compensation $______ Child Support $_______

Other (Alimony, Etc.) $__________ **TOTAL FAMILY INCOME$__________**

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE ActivePT TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

____ ____________
SIGNATURE OF PERSON MAKING REQUEST DATE:

_______________________________________ _____________
SIGNATURE OF SPOUSE/OTHER DATE:

DO NOT WRITE IN BOX – FOR OFFICE PERSONNEL USE ONLY

This document was received on ___________________ (date) by ____.
(Name/Title)

Approved by ____
(signature of office manager)