Penn Highlands Healthcare

Financial Assistance Policy

– *Plain Language Summary*

At **Penn Highlands Healthcare** we understand that when individuals come to us for care they could be experiencing something urgent that may be unfamiliar or at times frightening. At those times, concerns especially about having an unplanned medical bill should not stop them from having the necessary care they need. At Penn Highlands Healthcare we strive to provide quality service and safety to the communities we serve regardless of an individual's ability to pay. Our **Financial Assistance Policy (FAP)** exists to provide eligible individuals partially or fully discounted emergent or medically necessary hospital/physician care. Individuals seeking Financial Assistance must apply for the program, which is summarized below.

Eligible individuals: Patients receiving urgent or medically necessary care must submit a Financial Assistance Application (including required documentation), and who are determined eligible for Financial Assistance by PHH.

Eligible Services: Emergent and/or medically necessary healthcare services provided by Penn Highlands Healthcare (PHH), which includes Brookville, Clearfield, DuBois and Elk facilities, Penn Highlands Community Nurses and the Penn Highlands Physician Network (PHPN).

How to Apply: Financial Assistance Applications may be obtained and/or submitted as follows:

You can view the full Financial Assistance Policy or download an application by visiting our website at **www.phhealthcare.org/FAP**.

You may also Pick-up an application at the Business Office of any PHH facility at the addresses listed below. You can request an application to be mailed to you by calling any of the phone numbers indicated below:

100 Hospital Road, Brookville, PA 15825	814-849-1438
438 Front Street, PO Box 992, Clearfield, PA 16830	814-768-2484
204 Hospital Avenue, PO Box 447, DuBois, PA 15801	814-375-4200
763 Johnsonburg Road, St. Marys, PA 15857	814-788-8246
757 Johnsonburg Road, Suite 200, St Marys, PA 15857	800-841-9397

Determination of Financial Assistance Eligibility – Generally, individuals are eligible for financial assistance based upon their income level according to the federal poverty guidelines and their ability to pay.

- Individuals with a family income of 200% of the federal poverty guidelines or less may be eligible for a discount of 100%.
- Individuals with a family income of 201% to 250% of the federal poverty guidelines may be eligible for a discount of 80%.
- Individuals with a family income of 251% to 300% of the federal poverty guidelines may be eligible for a discount of 65%.

Eligible individuals will not be charged more for emergency or other medically necessary care than Amounts Generally Billed (AGB) to individuals with insurance.

Financial assistance is not available for individuals who opt out of available insurance coverage, or those who fail to reasonably comply with insurance requirements, such as obtaining authorizations or referrals.

Penn Highlands Healthcare

Financial Assistance Application

[ ] PH Brookville	[ ] PH Clearfield	[ ] PH DuBois	[ ] PH Elk	[ ] PH Community Nurses
100 Hospital Rd	P.O. Box 992	204 Hospital Ave P.O. Box 447	763 Johnsonburg Rd	757 Johnsonburg Rd, Ste 200
Brookville, PA 15825	Clearfield, PA 16830	DuBois, PA 15801	St Marys, PA 15857	St. Marys, PA 15857
(814) 375-4202	(814) 768-2484	(814) 375-4202	(814) 788-8246	(814) 781-1415

Patient Name(s): _____

Encounter/Account #(s): _____

GUARANTOR		**SPOUSE (Significant Other)**	
Name Date of Birth		Name Date of Birth	
Social Security Number	MRN (For Business Office Use Only)	Social Security Number	MRN (For Business Office Use Only)
Current Address # years:_____ [ ] Own [ ] Rent		Current Address # years:_____ [ ] Own [ ] Rent	
Street:		Street:	
City/State/Zip		City/State/Zip	
Home Phone:	Cell Phone:	Home Phone:	Cell Phone:
City/State/Zip		City/State/Zip	
Marital Status: [ ]Single [ ]Married [ ]Divorced [ ] Widow(er)		Marital Status: [ ]Single [ ]Married [ ]Divorced [ ] Widow(er)	
Total # residing in household:		Total # residing in household:	
Name & Adress Of Employer:		Name & Adress Of Employer:	
Position/Title: Yrs. Employed		Position/Title: Yrs. Employed	
Previous Employer(s) (if within the last year): Date of Termination		Previous Employer(s) (if within the last year): Date of Termination	

Please list any dependent children as reported on your last Federal tax return. Attach a separate sheet if necessary:

Child's Name	**Date of Birth**	**MRN (For Business Office Use Only)**

Documentation Needed for Financial Assistance

The following proof of income documents are required with the application:

**** Federal tax return including W2(s) for year(s):_____***
****Payroll stubs for last 2 months***
****Bank statements for current month and/or other income verification (last 2 months)***
****Copy of Medicaid Denial***

We ask all who apply for financial assistance to look for other funding also. Please check "Yes" or "No".

Does your employer or spouse's employer offer group health insurance? [ ]YES [ ]NO If yes, list insurance:_____
Does your employer reimburse you for any deductible? [ ]YES [ ]NO
Do you have a Health Savings/Flex Savings Account? [ ]YES [ ]NO If yes, list Balance:_____
Are you eligible for COBRA through a previous employer? [ ]YES [ ]NO
Do you have other types of insurance such as Allstate, AFLAC, etc? [ ]YES [ ]NO If yes, list insurance:_____
Were you denied Medicaid? [ ]YES [ ]NO ***If yes please attach copy of denial***
Have you applied for State assistance programs (CHIP, Marketplace, etc)? [ ]YES [ ]NO
Do you have family or church assistance? [ ]YES [ ]NO

Gross Earnings	**MONTHLY INCOME**		
	Guarantor	Co-Applicant	TOTAL
Wages	$	$	$
Social Security			
Self Employed			
Pensions			
Work Comp.			
Interest/dividends			
Rental			
Disability/SSI			
Military Benefits			
Child Support			
Alimony			
Unemployment			
Other			
Total monthly household Income	$	$	$

ASSETS

TYPE	Financial Institution(s)	Total Balance Amount
Cash		$
Savings Account(s)		$
Checking Account(s)		$
Stocks or Bonds		$
For Medicare Patients Only (as reporting required by Medicare):		
401(k)		$
IRA		$

Other situations we should be informed of in order to understand your need for financial assistance. You may attach a separate sheet if more space is needed.

I hereby state that the information given herein is true and correct. I authorize any required verification, including credit bureau report. I understand that if this information is determined to be false or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.

Responsible Party Signature _____ Date_____

Checklist of all required information to complete Application process:

[ ] Front and back of form filled out completely
[ ] Signed and dated
[ ] Copy of Medicaid Denial (if applicable)
[ ] Copies of current federal tax return including W-2s
[ ] Household income verification (pay stubs & bank statements) last 2 months

FOR BUSINESS OFFICE USE ONLY

Reviewed By: _____ ***Date of Review:*** _____

Date of Determination: _____ ***Date Applicant Notified:*** _____

Approval [ ] _____% Denial [ ] Reason: _____

Supervisor/Mgr/Director sign off: _____ ***Date:*** _____