EVANGELICAL
COMMUNITY HOSPITAL
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A. INTRODUCTION

EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program is the term applied to health services made available at no charge or at a reduced charge to persons unable to pay.

B. RESTRICTION OF BENEFICIARIES

EVANGELICAL COMMUNITY HOSPITAL will make medically necessary services available on an inpatient or outpatient basis to individuals who cannot afford to pay for such services. Services denied by medical insurance deemed “not medically necessary” are excluded from this Financial Assistance policy.

Financial Assistance will be offered six (6) months from the date of approval for future services covered under this policy for EVANGELICAL COMMUNITY HOSPITAL. Patients will need to reapply for Financial Assistance for Evangelical Medical Services Organization (EMSO) for each request for assistance.

A Medical Assistance (MA) denial is required to be submitted with a completed Financial Assistance application. This denial cannot exceed 6 months old. In the event an MA denial is over 6 months old the Financial Assistance application will be denied until a current MA denial can be obtained by the applicant.

Financial Assistance will be extended up to the fiscal year limit set forth by the CFO during the budget process.

PROVIDERS NOT COVERED

Providers not employed by EVANGELICAL COMMUNITY HOSPITAL but providing services to patients seen at EVANGELICAL COMMUNITY HOSPITAL, may elect not to accept these guidelines. These providers include but are not limited to Quantum Imaging, Family Practice Center, etc. All “elective” medical, diagnostic or surgical services performed, professional (physician) fees, and/or specialists (radiologist, etc.) are not subject to the EVANGELICAL COMMUNITY HOSPITAL Financial Assistance discounts.

MEDICAL NECESSARY CARE

The definition of medical necessity is explained in Pennsylvania regulations (55 Pa. Code §1101.21a), and the DPW "Clarification Regarding the Definition of 'Medical Necessity'" at 37 Pa.B. 1880 (April 27, 2007) and in the contracts between the Pennsylvania Department of Public Welfare and the HMOs.

To meet the Medicaid standard for Medical Necessity, any one of the three standards below can be met:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness condition, or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition or disability.
- The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities considering both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

The determination can be made either by prior authorization, concurrent review, or post-utilization. For a service to be medically necessary, it must be compensable under the Medicaid program. Determinations of medical necessity and denials of medical necessity must be in writing.

C. ADMISSION AND ABILITY TO PAY

EVANGELICAL COMMUNITY HOSPITAL will provide services at no charge or reduced charges to those who are

financially unable to pay for those services.

EVANGELICAL COMMUNITY HOSPITAL will not arbitrarily restrict the provisions of health services to certain individuals or groups.

EVANGELICAL COMMUNITY HOSPITAL will make available a written notice to each patient or their representative of the existence, criteria and mechanism for receiving Financial Assistance. The Hospital will create and maintain records demonstrating that the required criteria and mechanism are established. The Hospital will record any and all requests for Financial Assistance, the disposition and the dollar amount of EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program provided. In all instances, patient confidentiality will be protected.

EMERGENCY MEDICAL CARE

EVANGELICAL COMMUNITY HOSPITAL's policy is to provide emergency care to stabilize patients, regardless of their ability to pay in accordance with EMTALA. EVANGELICAL COMMUNITY HOSPITAL provides care for medical conditions to individuals, without discrimination and regardless of FAP eligibility and disallows actions that discourage individuals from seeking medical care. Following medical evaluation, non-emergent patients requiring Financial Assistance consideration should be reviewed and approved before additional services are provided.
EMERGENCY MEDICAL CARE

EVANGELICAL COMMUNITY HOSPITAL's policy is to provide emergency care to stabilize patients, regardless of their ability to pay in accordance with EMTALA. EVANGELICAL COMMUNITY HOSPITAL provides care for medical conditions to individuals, without discrimination and regardless of FAP eligibility and disallows actions that discourage individuals from seeking medical care. Following medical evaluation, non-emergent patients requiring financial assistance consideration should be reviewed and approved before additional services are provided.

D. FINANCIAL ELIGIBILITY AND DISCOUNTS

An individual notice of availability of EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program will be given to each patient or their representative prior to services being rendered, with the exception of emergency services. These notices shall be available in all registration areas of the Hospital and shall include the most current available "Household Income Guidelines" as published in the Federal Register.

Eligibility will be determined by comparing household family income against the income poverty guidelines. Income is defined as the total annual cash receipts before taxes from all sources. Patients qualifying for the Financial Assistance Program will not be charged more than the Amounts Generally Billed (AGB).

The Patient Accounts Director or his/her designee shall review all applications for EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program. It is the applicant's responsibility to provide proof of income. Reasonable benefits will be granted based on the information in Appendix A and applied to gross charges.

METHODS FOR APPLYING FOR FINANCIAL ASSISTANCE

On Line – Go to the EVANGELICAL COMMUNITY HOSPITAL website:

https://www.evanhospital.com/for-patients/financial-assistance-program-guidelines

The website provides information about the program and includes a downloadable application that can be completed and mailed to the address provided in the application.

By Mail – Patients or their representatives may contact the Financial Counselors at 570-522-4445 and 570-522-4841 and request an application be mailed to them.

In Person – Patients or their representatives may contact the Financial Counselors at 570-522-4445 and 570-522-4841 and request an appointment to come in a fill out an application.

By Phone – Patients or their representatives may contact the Financial Counselors at 570-522-4445 and 570-522-

4841 and request to fill out the application verbally. Appointments may need to be made. Patients or their representatives must then forward required documentation to complete the application process.

Free Copies of this Financial Assistance Policy, Application Form, and Summary are available in English and Spanish and can be obtained by calling 570-522-4445 or 570-522-4841 or going on line at https://www.evanhospital.com/for-patients/financial-assistance-program-guidelines.
Las copias de nuestra Política de ayuda financiera, el Formulario de solicitud y el presente Resumen están disponibles en español.

ACTIONS THAT MAY BE TAKEN IN THE EVENT OF NON-PAYMENT

1. If any individual fails to apply for financial assistance under the FAP by 240 days after the first statement is mailed, and the responsible individual has received the final statement, which includes the Plain Language Summary, then EVANGELICAL COMMUNITY HOSPITAL may initiate Extraordinary Collection Actions (ECA).
2. If a responsible individual has applied for financial assistance under the FAP in the last six months, and the Patient Access determines definitively that the responsible individual is ineligible for any financial assistance under the FAB, EVANGELICAL COMMUNITY HOSPITAL may initiate ECAs.
3. If any responsible individual submits an incomplete application for financial assistance under the FAP prior to the application deadline of 240 days, then ECAs may not be initiated until after each of the following has been completed:

    i. Patient Access provides the responsible individual with written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which will also be accompanied by the Plain Language Summary.
    ii. Patient Access provides the responsible individual with at least 30 days prior written notice of the ECAs that EVANGELICAL COMMUNITY HOSPITAL may initiate against the responsible individuals if the FAB application is not completed or payment is not made; however, provided the deadline for completion or payment may not be set prior to 240 days after the first post discharge statement.
    iii. If the responsible individual who has submitted the incomplete application completes the application for financial assistance, and the Patient Access determines definitively that the responsible individual is ineligible for any financial assistance under the FA policy, EVANGELICAL COMMUNITY HOSPITAL may initiate ECAs.
    iv. If the responsible individual who has submitted the incomplete application fails to complete the application by the completion deadline set in the notice described in item B, then ECAs may be initiated.
    v. If the responsible individual submits a financial assistance application, complete or incomplete, under the Financial Assistance Policy at any time during the application period, EVANGELICAL COMMUNITY HOSPITAL will suspend ECAs while the financial assistance application is pending. Question or concerns regarding applications or assistance, call 570-522-4445 or 570-522-4841.
    vi. If the responsible individual has questions regarding his or her statement, he or she may contact Patient Financial Services at 570-522-2552.
    vii. Upon approval for a Financial Assistance discount, any remaining balances are the responsibility of the patient/guarantor. Payments arrangements must be setup in accordance with the Billing and Collections Policy. For a copy of this policy please contact the Patient Financial Services department at 570-522-2552.

4. After the commencement of the ECAs is permitted under section 3 above, external collection agencies shall be authorized to report unpaid accounts to credit agencies. EVANGELICAL COMMUNITY HOSPITAL and external collection agencies may also take including but limited to telephone calls, mailing notices, and skip tracing to obtain payment for medical services rendered.

E. PERFORMANCE STANDARDS

1. Completed applications for EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program discounts will be collected by the Financial Counselors.

2. The Financial Counselors will review the application for accuracy. Patient/guarantor contact will be made to collect any absent information. Once completed, the application will be referred to the Director of Patient Accounts and/or his/her designee for evaluation, without exception.

F. PERFORMANCE MEASUREMENT

1. The Director of Patient Account's designee will review any and all EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program applications on a real-time basis. A signature from the Director of Patient Accounts is required for Financial Assistance write-offs in the amount of $3,000.00 or greater. Signatures from both the Director of Patient Accounts and the CFO are required for Financial Assistance write-offs in the amount of $5,000.00 or greater. Information relative to cumulative fiscal year data will be compiled and reported to the CFO and/or their designee.

2. The CFO and/or their designee will randomly audit EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program discounts applied annually.

G. PROCEDURE

Step 1 The Financial Counselors will identify patients and/or guarantors that may qualify for EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program relief as the direct result of job tasks and responsibilities.

The Financial Counselors will conduct a private interview with the patient and/or guarantor to discuss the Financial Assistance alternative and parameters.

The Financial Counselors will be responsible for review and screening for Medical Assistance. All patients seeking financial assistance must be screened by the Financial Counselors. Patients may be required to apply for Medicaid. Patients who refuse to be screened and/or refuse to apply for Medicaid will not eligible for Financial Assistance.

Step 2 The Financial Counselors will distribute the EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program application and assist in its completion, as necessary. Proof of income will be requested from the patient/guarantor and may consist of the following:

1. The most recent IRS tax return and W-2
2. Three months copy of the applicants most recent paychecks
3. Denial notice received from Medical Assistance, (not always necessary if prescreening determined the patient was ineligible)
4. Social Security Administration notice of benefits

Step 3 The Financial Counselors will refer the completed EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program application and any/all attachments to the Director of Patient

Accounts for review and handling. The Director of Patient Account's designee will prepare an adjustment form to be attached to the application and attachments.

Step 4 The Director of Patient Account's designee will enter comments that convey any and all actions taken in the notes feature of the hospital computer system.

Step 5 Based on the eligibility status results, the Director of Patient Accounts or designee will:

Eligibility Approved	Eligibility Denied
1. Will communicate the approval with the patient/guarantor. 2. Will review the completed adjustment form for the appropriate discount amount and adjustment code. 3. Will approve the form by signature on the appropriate line of EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program discounts of $2,999.99 or less. 4. Will refer the form to the Director of Patient Accounts for signature on Financial Assistance Program discounts of $3,000.00 or greater. 5. Will refer the form for authorization to the Chief Financial Officer for Financial Assistance Program discounts that are $5,000.00 or greater. 6. The duly executed adjustment form will be referred to the adjustment clear for entry into the Hospital computer system.	1. Will communicate the denial with the patient/guarantor. 2. Will make a comment on the patient account explaining all actions. 3. Will file all documentation and determinations in the "charity file."

501(r) DEFINITIONS:

Amounts Generally Billed (AGB): The amount generally billed to an Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) patient who has insurance coverage as defined in IRS Section 501(r)(5).

****Application Period:** The period during which Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) must accept and process FAP applications. This period shall be from the date of service until 240 days after Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) provides the patient with the first billing statement for the care delivered.

Application Process: A process by which a patient or their appropriate representative completes a paper or an electronic form that provides Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) with information on the patient's income, family size and assets. All applications will be evaluated on a case-by-case basis by appropriate Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) representatives taking into consideration medical condition, employment status, and potential future earnings.

Bad Debt: Uncollected patient financial liabilities that have not been resolved at the end of the patient billing cycle and for which there is no documented inability to pay.

Financial Assistance: Healthcare services that have been or will be provided but are never expected to result in cash inflows. Financial assistance results from a provider's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Financial Assistance or Financial Assistance Discounts: Discounts or elimination of payment for health care services provided to eligible patients with documented and verified financial need. Financial Assistance Discounts provided under this policy include:

- **Financial Assistance**: Financial help with medical bills based on income standards
- **Catastrophic Financial Assistance:** Discount provided to patients when _____ unreimbursed eligible medical expenses incurred in a one-year period exceed their annual household income

Eligible Health Care Services: Services which are emergent and other medically necessary care. Eligible Health Care Services exclude:

- Charges disallowed through utilization reviews or denials
- Any contractual allowances
- Cosmetic services or elective services that are not medically necessary
- Write-offs of amount due from third party payers
- Shortfall between reimbursement from government programs for the uninsured and the cost of services provided
- Write-offs of patients' balances when there is not an indication that the patient is unable to pay
- Experimental Services
- Transplant Service

Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Estimated Patient Liability: The estimated patient financial responsibility that is due to Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) for professional and technical charges for health care services the patient received. This amount is determined in compliance with the patient's insurance benefits for the specific scheduled service and includes deductibles, co-payments, co-insurance, and non-covered services.

Extraordinary Collections Actions: Actions which require a legal or judicial process, involve selling a debt to another party or reporting adverse information to credit agencies or bureaus. Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) will determine charity eligibility prior to taking any extraordinary collection action. Written notice must be provided at least 30 days in advance of initiating specific ECAs and meet informational requirements. As defined under IRS Codes Section 501(r), such actions that require legal or judicial process include:

- A lien
- Foreclosure on real property
- Attachment or seizure of a bank account or other personal property
- Commencement of a civil action against an individual
- Actions that cause an individual's arrest
- Actions that cause an individual to be subject to body attachment
- Wage garnishment

Family: The patient, the patient's spouse (regardless of whether s/he lives in the home) and all of the patient's children (natural or adoptive) under the age of eighteen (18) who live at home. If the patient is under the age of 18, "Family" includes the patient, his or her natural or adoptive parents (regardless of whether they live in the home), and the parent's other children (natural or adoptive) under the age of 18.

Financial Counselor: Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) representatives responsible for assessing a patient's liability, identifying and assisting with public funding options (Medicare, Medicaid, etc.), determining if patient is eligible for financial assistance, and establishing payment plans.

Federal Poverty Guidelines (FPG): Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services and in effect at the date(s) of service for which financial assistance may be available.

Gross charges: The total charges at the organization's full established rates for the provision of patient care services

before deductions from revenue are applied.

****Medically necessary:** As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

****Notification Period:** The period of time during which Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) will make every reasonable effort to inform the patient of the availability of financial assistance under this policy. This period shall be from the date of service until 120 days after Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) provides the patient with the first billing statement for the care delivered.

Private Pay: Patient identified as having no insurance coverage or opting out of their insurance coverage for specific services/events.

Presumptive Eligibility: A patient's eligibility for Evangelical Community Hospital and Evangelical Medical services Organization (EMSO) financial assistance determined by criteria demonstrating financial need other than information provided by the patient's family. Additional information received after qualifying for presumptive eligibility will not change the determination.

Screening Process: A process to determine if a patient qualifies for Financial Assistance that does not involve completing a financial assistance application. The screening process may be in person or on the telephone and utilizes a Third Party Vendor.

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: Insured patients who receive Eligible Health Care Services that are determined to be non-covered services or have limited benefit coverage by the insurance provider.

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APPENDIX A

CALCULATION OF AMOUNT GENERALLY OWED BY INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE

Evangelical Community Hospital and Evangelical Medical Services Organization limits the amount owed by individuals eligible under this Financial Assistance Policy who received services except for elective medical, diagnostic, or surgical services performed, professional (physician) fees, and or specialists (radiologist, etc.) to an Amount Generally Billed (AGB) to patients covered by Medicare and Private Insurers. In addition, Evangelical Community Hospital and Evangelical Medical Services Organization also limits the eligible patient's financial responsibility to less than total charges. Evangelical Community Hospital and Evangelical Medical Services Organization shall periodically, at least once a year, update the AGB calculation and re-evaluate the method used. The AGB shall be based on all services provided to Medicare and Private Insured patients fully adjudicated as of the end of the 12-month look back period ending on June 30th. The calculation of the current AGB is as follows:

Total Medicare and Private Insured Allowed Reimbursement / Total Medicare and Private Insured Gross Charges = AGB Percentage

(Current AGB is 37% effective July 1, 2018)

The eligible individual's financial responsibility is calculated as follows and applied to the patient liability only (Excluding any portion assumed or paid by insurance or other entities on behalf of the patient):

Total Gross Charges for the Services Rendered X AGB Percentage = Patient Financial Responsibility

Health and Human Services Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia							
FREE CARE		**85% Discount**		**70% Discount**		**55% Discount**	
SIZE OF HOUSEHOLD	**2016 POVERTY GUIDELINES**	**GREATER THAN**	**UP TO**	**GREATER THAN**	**UP TO**	**GREATER THAN**	**UP TO**
1	$12,140	$12,140	$16,146	$16,146	$18,210	$18,210	$24,280
2	$16,460	$16,460	$21,892	$21,892	$24,690	$24,690	$32,920
3	$20,760	$20,760	$27,637	$27,637	$31,170	$31,170	$41,560
4	$25,100	$25,100	$33,383	$33,383	$37,650	$37,650	$50,200
5	$29,420	$29,420	$39,129	$39,129	$44,130	$44,130	$58,840
6	$33,740	$33,740	$44,874	$44,874	$50,610	$50,610	$67,480
7	$38,060	$38,060	$50,620	$50,620	$57,090	$57,090	$76,120
8	$42,380	$42,380	$56,365	$56,365	$63,570	$63,570	$84,760
$4,160 ADD'L FOR EACH MEMBER OF THE HOUSEHOLD							

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INDIVIDUAL WRITTEN NOTICE TO ALL PATIENTS
NOTICE OF AVAILABILITY OF EVANGELICAL COMMUNITY HOSPITAL FINANCIAL ASSISTANCE PROGRAM
EFFECTIVE JULY 1, 2017

EVANGELICAL COMMUNITY HOSPITAL will make available a reasonable amount of Financial Assistance Services to persons eligible under applicable Federal Community Services Administration Guidelines. Patient eligibility for EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program is determined by measuring family income against the Income Poverty Guidelines established by the Federal Community Services Administration. The current requirements are:

Health and Human Services Poverty Income Guidelines for the 48 Contiguous States and the District of Columbia							
FREE CARE		**85% Discount**		**70% Discount**		**55% Discount**	
SIZE OF HOUSEHOLD	**2016 POVERTY GUIDELINES**	**GREATER THAN**	**UP TO**	**GREATER THAN**	**UP TO**	**GREATER THAN**	**UP TO**
1	$12,140	$12,140	$16,146	$16,146	$18,210	$18,210	$24,280
2	$16,460	$16,460	$21,892	$21,892	$24,690	$24,690	$32,920
3	$20,760	$20,760	$27,637	$27,637	$31,170	$31,170	$41,560
4	$25,100	$25,100	$33,383	$33,383	$37,650	$37,650	$50,200
5	$29,420	$29,420	$39,129	$39,129	$44,130	$44,130	$58,840
6	$33,740	$33,740	$44,874	$44,874	$50,610	$50,610	$67,480
7	$38,060	$38,060	$50,620	$50,620	$57,090	$57,090	$76,120
8	$42,380	$42,380	$56,365	$56,365	$63,570	$63,570	$84,760
$4,160 ADD'L FOR EACH MEMBER OF THE HOUSEHOLD							

**** If you need financial assistance please contact the Financial Counselor ****
570-522-4445 and 570-522-4841

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APPLICATION FOR EVANGELICAL COMMUNITY HOSPITAL FINANCIAL ASSISTANCE PROGRAM

Date of Application _____

Applicant Name _____

SS# _____ DOB _____ Phone_____

Address _____

Address _____

City _____ ST _____ZIP_____

Members of Household

_____ SS# _____ DOB _____

_____ SS# _____ DOB _____

_____ SS# _____ DOB _____

_____ SS# _____ DOB _____

_____ SS# _____ DOB _____

_____ SS# _____ DOB _____

	Account#	**Amount**
Patient Account(s) #/Amount	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

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INCOME (Include all household members)

	Total last 3 Months	Total Last 12 Months
Gross Wages	_____	_____
Social Security Benefits	_____	_____
Pension Income	_____	_____
Public Assistance	_____	_____
Dividend & Interest	_____	_____
Rental Income	_____	_____
Farm or Self Employment Income	_____	_____
Unemployment Compensation	_____	_____
Worker's Compensation	_____	_____
Strike Benefits	_____	_____
VA Benefits	_____	_____
Military Family Allotments	_____	_____
Alimony	_____	_____
Child Support	_____	_____
Other Income	_____	_____
TOTAL INCOME (before taxes)	_____	_____

Please provide copies of your most recent 1040 and W-2 and/or three months of current pay stubs, and medical assistance notice of denial or eligibility (Medical Assistance denial notice must be dated within 6 months of this application). Additional information on assets may be requested.

EMPLOYER INFORMATION

Head of Household Employer Name _____

Employer Address _____

Additional Employer Names_____

Employer Address _____

I certify that the above information is true and correct to the best of my knowledge and further agree that falsification herein will disqualify me or my dependent(s) for charitable services. I understand the information submitted is subject to verification.

_____ _____

Patient Signature Date

_____ _____

Responsible Party Signature Date

EVANGELICAL
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Date: January 29, 2019

Account Number:

Dear _____ :

Please complete the attached EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program application and return it within 15 days using the self-addressed envelope provided for your convenience. Medical Assistance requires that you apply for eligibility within 90 days from your most recent date of service (special cases may be exempt from applying for Medical Assistance). A Medical Assistance notice of approval or denial will be sent to you. Please include your Medical Assistance denial with this application. It is very important that this application be filled out completely. We at EVANGELICAL COMMUNITY HOSPITAL are committed to the care and improvement of human life. We are also committed to providing quality care that is sensitive, compassionate, promptly delivered and cost effective. Our facility provides EVANGELICAL COMMUNITY HOSPITAL Financial Assistance Program to individuals who meet the Federal Poverty guidelines and is compliant with their rules and regulations.

To enable us to make a determination, please furnish us with the following documents to prove income:

1. Documentation of the gross monthly income for you and for all members of your household.
2. Medical Assistance notice of denial. Please call the Financial Counselors Erin Gramley and Michael Jason so they can screen for Medical Assistance. If you do meet the criteria they will set-up an appointment for you to come in and fill out the application. If you do NOT meet the criteria they will fill out the notice of denial.
3. Copies of your entire income tax return(s) from the last calendar year.
4. If currently employed copies of pay stubs for the last 3 months.
5. Copies of Social Security Eligibility Income statement(s), where applicable.
6. Please attach an additional page should the financial worksheet not have enough space for your information. Upon receipt of this information, we will review all information provided to make a determination compliant with Federal regulations.

Your application cannot be considered if it is not signed and dated or if any of the requested documentation is not received. The application must be returned with **15 days** from the date of this letter. Failure to submit documentation may result in denial of your request. Please return by: _____

If you have any questions or need assistance, please feel free to contact our Financial Counselors,
Erin Gramley at 570-522-4445 and Michael Jason at 570-522-4841.

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Your request for Financial Assistance has been approved and the following determination made.

Original Total Balance _____

Discount _____

New Balance Due _____

Your request for Financial Assistance has been denied for the following reason:

_____ Your income levels exceed the poverty guidelines.

_____ You did not furnish information necessary to substantiate your income.

_____ Other

This determination was made on _____

Sincerely,

EVANGELICAL COMMUNITY HOSPITAL