FAITH REGIONAL HEALTH SERVICES

Patient Financial Services
2700 W. Norfolk Ave., Norfolk, NE, 68701
Phone: (402) 371-4880 | Fax: (402) 844-8351
FRHS.ORG |

Dear Faith Regional Patient,

You are receiving this financial assistance application because you do not have health insurance, or you may not have health insurance that covers your hospital services received at Faith Regional Health Services or clinical services received through Faith Regional Physician Services. Faith Regional offers assistance to patients to identify options for health insurance to meet your healthcare needs. Health insurance options include but are not limited to employer sponsored coverage, Medicaid, Medicare, Marketplace and COBRA. You may also be a candidate for disability benefits through the Social Security Administration. The service area for financial assistance is Madison County and surrounding counties in which Faith Regional offers services. Prior to receiving financial assistance, you will need to enroll in the health insurance coverage option available to you and/or file a disability claim.

If your income is at least 100% of the Federal Poverty Level, you may be eligible to receive cost assistance through the Health Insurance Marketplace (Marketplace) for your health insurance. If you are eligible for the Marketplace, you will be asked to apply for, enroll in, and pay your health insurance premium cost. Open Enrollment for the Marketplace is typically November 1 through December 15 each year. If you meet the eligibility requirements for the Marketplace and enrollment is not open, financial counselors will speak with you to determine if you meet the requirements for a Special Enrollment Period (SEP). If you meet the requirement, you will be asked to apply and enroll. If ineligible for a Special Enrollment Period and you are approved for financial assistance, your financial assistance will end on or before the day preceding the Marketplace open enrollment date. You will then need to complete a Marketplace application for health insurance during Open Enrollment and pay your first month's premium to extend your financial assistance beyond this date.

If found eligible for employer sponsored health insurance coverage, your financial assistance will end one day prior to your open enrollment period with your employer.

Sincerely,
Faith Regional Financial Counseling

I understand that I must apply for all eligible health insurance coverage and disability benefits as determined by a Financial Counselor prior to being eligible for financial assistance at Faith Regional. I understand that Faith Regional does not offer health insurance and can only provide financial assistance to help me pay my medical bills at Faith Regional for a limited time period before I am asked to reapply. I understand that the service area is Madison County and surrounding counties in which Faith Regional offers services.

Patient Name	Patient Signature	Date
Financial Counselor Name	Financial Counselor Signature	Date

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Patient Financial Assistance Checklist

☐ **Complete the entire Financial Assistance Application.**

- Submit the application within the Application Period. The application period begins thirty (30) days prior to a scheduled procedure/visit and ends on the 240th day after the date the first post-discharge (whether inpatient, outpatient, or clinic visit) billing statement is provided to the patient.
- If all the required information is not submitted with your application a request letter will be sent to you. You will have ten (10) days from the date of the letter to supply the required information. If the required information is not returned in the time frame requested your application will be denied.
- Complete applications for Governmental Assistance Programs including, but not limited to, Medicaid and Marketplace insurance. Faith Regional offers assistance through a third party to assist in screening for these services. Failure to comply and/or cooperate may result in denial of your Financial Assistance Application.
- Additional documentation may be requested at any time in order to properly evaluate your financial needs for assistance. If the additional information is not returned in the time frame requested your application will be denied.
- Your cooperation in completing this application is important. The amount of assistance you receive is determined by your gross income, family size, and assets so please complete the form accurately.

☐ **Provide Required Documentation**

Proof of Income

- Most recent federal tax return. If submitting the application after April 15th, you will be required to submit the tax return for the most recent year. If you do not file a tax return, you will need to provide a letter confirming non-filing status by calling 1-800-908-9946 or make a request at IRS.gov/transcript.
- Previous three months of paycheck stubs for all adults in the household. If you do not have a paycheck stub, please provide a letter from your employer stating your income information. If you are a non-exempt employee, the letter needs to include your hours/week, hourly rate, and overtime rate.
- Previous three-months of complete bank statements for all accounts (checking, savings, health savings accounts, etc.)
- Self-Employed Income information. Provide a copy of your most recent federal tax return and a profit and lost statement for the last three months.
- Unemployment, Disability, and/or Social Security Income Information Benefit Letter
- Child Support and/or Alimony Income Information
- Worker's Compensation Income Information
- Military Income Information
- Previous three months statements for stocks, bonds, annuities, and CD's.

Patient Financial Assistance Checklist *(cont.)*

Proof of No-Income

- Letter of support-A letter from whomever you live stating that support in the form of food, shelter, and any other financial support. (This may be a friend, family member, or a shelter.)

- Letter showing denied unemployment compensation.

Household size

- Household size will be determined by those listed on the submitted tax return. If you would like additional individuals considered for household size, please provide proof of residency such as a utility bill or school enrollment information.

Net Worth

- List value of property and the current amount you owe on these items. Please provide most recent loan statement for each item.
  - Home
  - Land
  - Vehicles
  - Etc.

- Provide statements for all other unsecured debts such as personal loans and credit cards.

Proof of Residency

- Please provide a copy of electric or gas bill.

☐ **Sign, Date and Return the application with required documentation listed above.**

- You may contact one of our Financial Counselors at one of the following phone numbers or by e-mailing **financial_counselors@frhs.org**.
  - **Last names beginning with A through H (402) 644-7331**
  - **Last names beginning with I through P (402) 644-7366**
  - **Last names beginning with Q through Z (402) 844-8320**

- You can submit your application by:
  - E-mail: **financial_counselors@frhs.org**
  - Mail or In-Person: Faith Regional Health Services
2700 Norfolk Ave.
Norfolk, NE 68701

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☐ **New Application** ☐ **Renewal Application**

#1 Responsible Party

Last name	First name	Middle name	
Address	City	State	Zip Code
Social Security	Date of Birth	Age	
Home phone	Cell phone		
Employer Name	Years employed	Work phone	

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow/Widower

#2 Spouse

Last name	First name	Middle name	
Address (if different from Patients)	City	State	Zip Code
Social Security	Date of Birth	Age	
Home phone	Cell phone		
Employer Name	Years employed		

#3 Dependents

Name	Relationship	Date of Birth
1		
2		
3		
4		
5		
6		
7		
8		

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☐ **New Application** ☐ **Renewal Application**

#4 Insurance Information

Does anyone in the household have health insurance? ☐ Yes ☐ No

Insured Name #1	Health Insurance Name	Policy number
Insured Name #2	Health Insurance Name	Policy number

#5 Household Monthly Gross Income

	Responsible Party	Spouse
Employment (**Gross Earnings**)	$	$
Self Employment	$	$
*Business Type ______________	$	$
Social Security	$	$
Real Estate Rental Income	$	$
Unemployment - Date Ended	$	$
Disability	$	$
Workmen's Compensation	$	$
Child Support	$	$
Alimony	$	$
Military Income	$	$
Income from Family/Friends	$	$
Other/Cash Contributions	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed.

#6 Savings and Investments Assets

☐ I do not have a checking account ☐ I do not have a savings account ☐ I do not have a health savings account

	Responsible Party	Spouse
Checking Account Balance	$	$
Savings Account Balance	$	$
Health Savings Account Balance	$	$
Retirement/IRA's/401k/403b	$	$
CD/Annuities/Dividends/Interest	$	$
Stocks/Bonds/Interest/Life Insurance	$	$
Other Savings and Investments	$	$
* ______________	$	$
TOTAL	$	$

Use additional paper to include any other household members incomes not listed.

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#7 Other Assets

Primary Residence	Acres	Owner/How Held		Balance Remaining $	Current Value $
Other Real Estate	Acres	Owner/How Held		Balance Remaining $	Current Value $
Other Real Estate	Acres	Owner/How Held		Balance Remaining $	Current Value $
Vehicle #1	Year/Miles	Make	Model	Balance Remaining $	Current Value $
Vehicle #2	Year/Miles	Make	Model	Balance Remaining $	Current Value $
Vehicle #3	Year/Miles	Make	Model	Balance Remaining $	Current Value $
Land	Acres	Owner/How Held		Balance Remaining $	Current Value $
Land	Acres	Owner/How Held		Balance Remaining $	Current Value $
Land	Acres	Owner/How Held		Balance Remaining $	Current Value $
Boat	Year	Make	Model	Balance Remaining $	Current Value $
Camper/RV	Year	Make	Model	Balance Remaining $	Current Value $
Motorcycle	Year	Make	Model	Balance Remaining $	Current Value $
ATV	Year	Make	Model	Balance Remaining $	Current Value $
Other	Description			Balance Remaining $	Current Value $
				TOTAL $	**TOTAL** $

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#8 Unsecured Liabilities (continued)

Credit Cards		Loans	
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $
Name	Balance $	Type	Balance $

Complete this Section if you are un-insured or have a high deductible insurance plan.

#9 Pre-Screening for Alternate Payer Sources

Question		
1. Have you applied for Marketplace Health insurance within the last year?	☐ Yes Date__________	☐ No
1a. If Yes, what was the result of the application?	☐ Yes	☐ No
2. Is anyone in the household Pregnant?	☐ Yes	☐ No
3. Has anyone in the household miscarried in the last 90 days?	☐ Yes	☐ No
4. Is anyone in the household under 19 years old?	☐ Yes	☐ No
5. Is anyone in the household currently or expected to be physically or mentally disabled for the next 12 months.	☐ Yes	☐ No
6. Did you lose health insurance coverage within the past 60 days?	☐ Yes Date__________	☐ No
6a. Are you eligible for COBRA Benefits? Please list employer____	☐ Yes	☐ No
7. Have you had an increase in income?	☐ Yes	☐ No

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Other Comments

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Assignment of Rights

I understand that proof of income (see Financial Assistance Checklist) is required to process my application. I also understand that more information may be requested before my eligibility can be determined. I hereby acknowledge that the information listed on this application is true and correct. If any information given proves to be untrue or is withheld, I understand the hospital may take whatever action is appropriate. I agree that I will repay the assistance I was rewarded if I receive payment of any kind for the medical services covered by this application. Examples of this would be: insurance payments, payments from government programs, lawsuit settlements, or any other source of payment received.

Signature	Date	Signature	Date

Faith Regional Health Services will not grant financial assistance on procedures that are not deemed medically necessary such as; fertility testing, fertility treatment, cosmetic procedures, etc. You must be a US Citizen, US National, or alien lawfully present in the United States in order to qualify for any type of financial assistance offered by Faith Regional Health Services. Exceptions to this may be approved by the CFO or his/her designee. Failure to cooperate with Faith Regional or their third-party designee to screen and/or apply for alternate payer sources such as Medicaid, Marketplace Insurance, etc. disqualifies you from the financial assistance program offered by Faith Regional Health Services. In the future if your financial situation improves and you would like to remember the assistance you received please consider making a donation to the Faith Regional Health Services Foundation.

Faith Regional Plain Language Summary

Faith Regional believes that medically necessary and emergency health care services should be accessible to all, regardless of age, gender, religion, cultural background, physical mobility or ability to pay. Faith Regional is committed to providing health care services and acknowledges that in some cases the patient will not be financially able to pay for the services received.

Patients That Qualify For Financial Assistance

1. Faith Regional determines whether you qualify for financial assistance based on your income and household size compared to the Federal Poverty Guidelines published annually by the U.S. Department of Health and Human Services.
2. Patients who are Uninsured or Underinsured and whose Yearly Household Income is less than or equal to 400% of the Federal Poverty Level (FPL) may qualify for financial assistance.
3. If you are eligible for financial assistance, you will not be charged more than amounts generally billed to patients who have health insurance and will be provided financial assistance based on a sliding fee scale comparing household income to FPL.
4. Faith Regional may limit eligibility for financial assistance based on a patient's residency in relation to Madison County, NE, and other factors as set forth in the Financial Assistance Policy.
5. Please go to www.frhs.org for a list of all physicians to determine whether a specific physician follows the Faith Regional Financial Assistance Policy.

How To Apply

Faith Regional encourages anyone that believes they may qualify for financial assistance to complete and submit a financial assistance application to Financial Counseling at Faith Regional Health Services, 2700 Norfolk Avenue, Norfolk, Nebraska or electronically by e-mailing the application and supporting documentation to **financial_counselors@frhs.org**.

A copy of the Policy and a financial assistance application may be obtained at no charge by going to the Faith Regional's website, www.frhs.org, or by visiting a Financial Counselor or Registration at 2700 Norfolk Avenue, Norfolk, Nebraska. The Policy and a financial assistance application may also be sent to you by mail free of charge by contacting Financial Counseling at (402) 371-4880.

Further Information & Assistance With Applying

If you have questions about financial assistance or need assistance with applying for financial assistance, you may contact Financial Counseling at 2700 Norfolk Avenue, Norfolk, Nebraska or by calling (402) 371-4880.

Spanish translated copies of this summary, the policy and a financial assistance application are available on the Hospital's website at www.frhs.org, upon request from Financial Counseling at 2700 Norfolk Avenue, Norfolk, Nebraska or by calling (402) 371-4880.