

SOUTH LYON MEDICAL CENTER

SUBJECT: FINANCIAL ASSISTANCE POLICY

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SLIDING FEE APPLICATION

Once your application is submitted for review and upon approval, you may be eligible for a discount ranging from fifty-five percent (55%) to one-hundred percent (100%) based on your household size and monthly income.

If approved, coverage will apply to Clinics visits, Emergency Department visits and outpatient lab work and radiology services. Applicants approved for this program will be eligible for one (1) year from the date of decision.

Applicants who are approved are responsible to pay their percentage at the time of service for non-emergency and other non-medically necessary care or make arrangements in advance with the Financial Counselor.

Please complete the following application and return with the following documentation:

- All monies received within the last sixty (60) days (pay stubs, government letter of assistance or copy of check or child support payments) for all members of household.
- Copy of last income tax return or letter explaining why you do not file.
- W-2s, 1099s for previous tax year.
- Photo ID for all adults in the household. Social Security card for all members of the household (or birth certificate).
- Rent receipt or current utility bill showing current address.
- If rent and/ or utilities are provided by employer, please provide verification and value signed and dated by employer.
- If during the review of your application it appears you or a member of your household may be eligible for a state or federal program, you may be required to submit an application before approval of the Sliding Fee Scale Application. If an applicant is found to qualify for an assistance program, the Sliding Fee Scale Application will be amended to reflect that.

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Please allow up to fourteen (14) days for processing of application.

South Lyon Medical Center is an equal opportunity provider. South Lyon Medical Center reserves the right to resent or deny approval of any discount if the applicant knowingly and willfully submits information that is identified or found to be fictitious.

Any changes in come or family size must be reported within ten (10) days.

If you have any questions regarding the program, please feel free to contact the Financial Counselor.

463-2301 ext. 6437

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STATEMENT OF FINANCIAL CONDITION (Attachment A)

PATIENT NAME _____ SPOUSE _____

ADDRESS _____ PHONE _____

ACCOUNT # _____ SSN: _____

(PATIENT) (SPOUSE)

FAMILY STATUS: List all dependents eighteen (18) years of age or under, full time student, or disabled.

Proof of student or disability may be required.

| Name | Age | Relationship |
|-------|-------|--------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

EMPLOYMENT & OCCUPATION

Employer (or business name): _____ Position: _____

Contact Person & Telephone: _____

Spouse Employer: _____ Position: _____

Contact Person & Telephone: _____

CURRENT MONTHLY INCOME

Start: Gross Pay (before deductions) _____

Add: Income from Operating Business (if Self-Employed) _____

Add: Other Income: _____

Interest & Dividends _____

From Real Estate or Personal Property Social Security _____

Other (specify): _____

Alimony or Support Payments Received _____

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Subtract: Alimony, Support Payments Paid (_____)

Equals: Total Current Monthly Income (add Patient+ Spouse Income from above)_____

FAMILY SIZE

Total Family Members (add patient, spouse & dependents from above) _____

This institution is an equal opportunity provider

By signing this form, I agree to allow South Lyon Medical Center and its representatives to check employment and credit history for the purpose of determining my eligibility for a financial discount. I understand that I may be required to provide proof of the information I am providing.

(Signature of Patient or Guarantor)

(Date)

(Signature of Spouse)

(Date)

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CHARITY CARE CALCULATION WORKSHEET

Patient Name: _____ Patient Account #: _____

Special Considerations/Circumstances:

| | Yes | No |
|---|--------------------------|--------------------------|
| Does Patient have Insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is Patient Eligible for Medicare? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is Patient Eligible for Medicaid? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is Patient Eligible for Other Government Programs (I.e. Crime Victims, etc.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| Is Patient Self-Pay? | <input type="checkbox"/> | <input type="checkbox"/> |

Charity/Financial Assistance Calculation:

Total Combined Current Monthly Income \$ _____

Family Size (From Statement of Financial Condition) _____

Qualification for Charity Care/Financial Assistance (circle one): Full Partial
(Identify using eligibility guide) Catastrophic No Eligibility

Partial Charity Write-off Calculation (complete this section only if patient qualifies for partial charity care):

A. Total Charges \$ _____
B. Sliding fee % (Attachment B) _____
C. Patient Liability (Line A times Line B) \$ _____
D. Discount Amount (Line A minus line C) \$ _____

Catastrophic Charity Write-off Calculation (complete section only if patient qualifies for catastrophic charity w/o):

A. Patient Liability \$ _____
B. Annual Income \$ _____
C. Patient Liability as Percent of Annual Income _____ %
D. Is Line A divided by Line B greater than .30 (30%)? Yes No
E. If no, patient is not eligible for this type of write-off _____ \$0 _____

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F. If yes, multiply Line B by 30% to identify the patient liability amount \$ _____

G. If yes, Subtract line F from Line A to identify the write-off amount \$ _____

Total Amount of Recommended Charity Write-off(s): \$ _____

Worksheet Completed by: _____ Phone: _____

Approved by: _____

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AUTHORIZED FOR CHARITY WRITE-OFF

APPROVAL MATRIX: to be developed by each entity in accordance with departmental make-up, levels of management and size. For example:

| | |
|--|----------------|
| Chief Executive Officer and/or Chief Financial Officer | Above \$10,000 |
| Chief Executive Officer/ Chief Financial Officer | Up to \$10,000 |
| Chief Executive Officer/ Chief Financial Officer | Up to \$1,000 |

Approval Signature(s)

Date: _____

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NOTIFICATION FORM ELIGIBILITY DETERMINATION FOR CHARITY CARE

South Lyon Medical Center has conducted an eligibility determination for charity care for:

| PATIENT'S NAME | ACCOUNT NUMBER | DATE (S) OF SERVICE |
|----------------|----------------|---------------------|
|----------------|----------------|---------------------|

The request for charity care was made by the patient or on behalf of the patient on _____.
This determination was completed on: _____.

Based on the information supplied by the patient or on behalf of the patient, the following determination has been made:

_____ Your request for charity care has been approved for services rendered on _____.
After applying the charity care reduction, the amount owed is \$ _____.

_____ Your request for charity care is pending approval. However, the following information is required before any adjustment can be applied to your account:

_____ Your request for charity care has been denied because:

REASON:

If you have any questions on this determination, please contact:

Financial Counselor 463-2301 ext. 6437