



FINANCIAL ASSISTANCE APPLICATION AND INSTRUCTIONS

Geary Community Hospital (GCH) understands that there are situations where individuals cannot afford to pay their hospital bill. In an effort to identify and assist these individuals, GCH has established a couple of programs to provide financial assistance.

Charity care is defined as the value of healthcare services provided at no charge or at a reduced charge to patients who do not have, or cannot obtain, adequate financial resources to pay for their care.

Requirements for financial assistance at GCH:

- Individual must be screened for public benefits. This is a service offered by GCH in a partnership with Haase & Long. Haase & Long staff are available to assist individuals who may be eligible for healthcare coverage under Medicaid, disability, etc.
- Individual must be a resident of Geary County or their primary care practitioner (M.D., physician assistant, nurse practitioner) must be on the GCH medical staff.
- Individual must complete a Financial Assistance Application and include 12 months worth of financial information to show that the household's net income falls at or below 150% of the Federal Poverty Guidelines (see table below).

2009 Poverty Guidelines

Persons in Household	Poverty Guideline	150% of Poverty
1	10,830	16,245
2	14,570	21,855
3	18,310	27,465
4	22,050	33,075
5	25,790	38,685
6	29,530	44,295
7	33,270	49,905
8	37,010	55,515

Individuals who fall at or below the poverty guideline and meet the above criteria will be eligible for 100% discount on their hospital bills for up to 6 months as long as the individual's financial situation doesn't change.

Individuals who fall above the poverty guideline up to and including 150% of the Poverty Guideline and who meet the above criteria will be eligible for a 30% low income discount on their hospital bills for up to 6 months as long as the individual's financial situation doesn't change.

These discounts DO NOT apply to professional services (e.g. doctor fees).



TIPS FOR COMPLETING THE FINANCIAL ASSISTANCE APPLICATION

Upon receiving this packet, GCH staff will mark a Due Date in the upper right hand corner. This date represents 10 days from receipt of the application. This is to help make sure your application is processed quickly.

The following is a guide to help in completing the application form that is attached.

<u>FIELDS</u>	<u>DESCRIPTIONS</u>
PATIENT NAME	Enter the name of the primary individual who is applying for the financial assistance.
OTHER INDIVIDUALS	Enter name(s) of individuals who you are financially responsible and may also have hospital bills that you are financially responsible for. These individuals may include your children and/or spouse. If you need more space, please feel free to write on the back of the application or use a separate sheet of paper.
RELATIONSHIP	For each individual listed, please enter their relationship to you—the primary individual who is applying for the financial assistance
ADDRESS	Enter your current residence including your street name, city, state and zip. We will use this information to send a formal letter of determination.
TELEPHONE NUMBER	Please provide a telephone number where we can reach you if we have questions or need additional information on your application.
PRIMARY CARE PHYSICIAN	Please enter your primary care physician who handles the majority of your healthcare.
HAVE YOU APPLIED FOR PUBLIC BENEFITS	Enter whether you have ever applied for public benefits (e.g. Medicaid, SSI, etc.). Indicate whether you were ever approved and the last date you did have these benefits available.
HAVE YOU MET WITH THE HOSPITAL REPRESENTATIVE	Report if you have already worked with Haase & Long (financial screening).
TOTAL NUMBER OF DEPENDENTS	Enter the number of eligible dependents as would be reported to the IRS (tax returns)
NET HOUSEHOLD INCOME	Enter the amount of net household income. This includes household salaries (take-home pay), social security payments, child support payments, bank interest, dividends, etc.
SPECIAL CIRCUMSTANCES	Enter any special circumstances (i.e. recent job changes, health issues of other family members, etc.) that will assist us in making a determination.



FINANCIAL ASSISTANCE APPLICATION

PATIENT NAME: _____ DATE: _____

OTHER INDIVIDUALS WHO ARE INCLUDED ON THIS APPLICATION:

INDIVIDUAL NAME	RELATIONSHIP
_____	_____
_____	_____

ADDRESS: _____ TELEPHONE: (____) _____

PRIMARY CARE PHYSICIAN: _____

HAVE YOU APPLIED FOR PUBLIC BENEFITS (e.g. MEDICAID)? YES NO

IF YES, WERE YOU APPROVED? YES NO

IF YES, DATE LAST APPROVED _____

HAVE YOU BEEN IN CONTACT WITH THE HOSPITAL'S FINANCIAL SCREENER TO SEE IF YOU MAY BE ELIGIBLE FOR SOME SORT OF PUBLIC BENEFIT?

YES NO

RESULTS OF THE REVIEW: _____

TOTAL NUMBER OF DEPENDENTS: _____ NET HOUSEHOLD INCOME: \$ _____

SPECIAL CIRCUMSTANCES: _____

Net Household Income includes:

- Wages/Salaries (after taxes & withholdings)
- Child Support
- Social Security
- Interest/Dividends

Return to:

Geary Community Hospital
ATTN: Patient Financial Services
1110 Saint Marys Road; Suite 306
Junction City KS 66441

Please also note under 'Special Circumstances' any assets, which may include rental properties, businesses, etc.