Florida Medical Clinic, P.A.
Policy and Procedure Health Information Management
4019 Charity Care and Financial Hardship

CEO: _____ Effective Date: May 28, 2015

Revision Dates: 1/1/2016

Review Dates: _____

POLICY

Florida Medical Clinic, P.A. is established to meet the healthcare needs of the community. This policy will provide a systematic method for identifying and distributing charity care and financial hardship to patients who qualify.

PURPOSE

Florida Medical Clinic, P.A. will provide charity care or financial hardship to patients that are unable to pay for services.[i]

PROCEDURE:

CHARITY CARE

1. If an uninsured patient was treated in the hospital, the Collections staff will retrieve the patient's hospital face sheet pertaining to the date(s) of service being billed.
   a. If it is determined by the insurance plan code utilized on the face sheet that the patient qualified for charity through the hospital, the patient's hospital charges will be discounted 100%.
   b. If the insurance plan code on the face sheet does not indicate charity, the patient will be required to provide supporting documentation, i.e. letter from hospital granting charity.
   c. If the insurance plan code on the face sheet indicates the patient did not qualify for charity through the hospital, the patient may apply for financial assistance or hardship.

2. Uninsured or underinsured patients requesting financial assistance will need to complete a **Financial Assistance Application.** Prior to reviewing the application, all applicants Medicaid statuses will be verified using the Florida Medicaid website.
   a. The following documentation is required for proof of income for **all** persons over the age of 18 residing in the household:
      i) Family income for 12 months;
      ii) Three current months of bank statements, savings and checking (money market if applicable)
      iii) Three current employer pay stubs, if unavailable, a signed verification of current wages from the employer;
      iv) Federal income tax return for the preceding tax year and W-2 form;
      v) Forms approving/denying unemployment/workers compensation;

vi) Written verification from public welfare agencies, or any other governmental agency which can attest to the patient's income status for the past 12 months;

vii) A Medicaid remittance voucher which reflects that the patient's Medicaid benefits for the Medicaid fiscal year have been exhausted.

b. While the Financial Assistance Application is under review, the patient's account will be placed on hold until determination of the application is made. The patient will have a maximum of 4 weeks to provide all requested information.

c. Determination is based on 150% of the current year's Federal Poverty Guidelines.

d. Once approved, the balance will be discounted at 100%.

3. All documentation used in determining Charity/Financial Assistance will be retained for audit purposes.

4. Florida Medical Clinic has the right to request information from the credit reporting agencies regarding available credit and credit score.

[i] *This policy does not apply towards Ambulatory Surgery Center services.*

Florida Medical Clinic

Your Life. Our Specialty.

Dear Valued Patient,

In order to consider your application for Financial Hardship you must supply copies of supporting documentation for **all** persons 18 years or older residing in the household. If the application is returned without the proper documentation or is incomplete, it will automatically be denied.

Required documentation includes:

- **3 Current Months Bank Statement; Checking and Savings**
- **3 Current Employer Pay Stubs**
  - **If unavailable, a signed verification of current wages from employer**
- **Current Federal Income Tax Return or W2**
- **Government Assistance**
- **SSI/Disability**
- **Form Approving/Denying Unemployment/Workers Compensation**

Please return the above requested information along with the application within two weeks in order to be considered for Financial Hardship.

If you have any questions, please call us at 813-528-4979.

Respectfully,

Financial Assistance Department

PATIENT /APPLICANT
FINANCIAL STATEMENT

Florida Medical Clinic
Your Life. Our Specialty.

LIST ALL HOUSEHOLD FAMILY MEMBERS BY LEGAL NAME

LAST NAME	FIRST	DATE OF BIRTH	AGE	RELATION TO PATIENT	OCCUPATION	SOCIAL SECURITY NUMBER	LAST YEAR'S ANNUAL GROSS

PATIENT INFORMATION	***Please provide the following for all members of household:***	
County of Residence:	INCOME/ASSISTANCE FROM	
Home Telephone Number:	INVESTMENT INCOME	
Date of last worked day	SOCIAL SECURITY INCOME	
Have you applied for Medicaid or county assistance? Yes ❑ or No ❑	STATE AID - SSI, AFDC, MEDICAID	
If yes, when and where?	FOOD STAMPS	
Have you applied for social security disability (SSI/SSD)? Yes ❑ or No ❑	PENSION INCOME	
If yes, when and where?	SAVINGS INTEREST	
Has the guarantor been hospitalized in the last 60 days? Yes ❑ or No ❑	WORKERS COMP. INCOME	
If yes, when and where?	UNEMPLOYMENT COMPENSATION	
	CHILD SUPPORT /ALIMONY RECD	
	RENTAL INCOME	
	MONEY FROM FAMILY / OTHER	
	CURRENT YEAR INCOME	$ _____

ASSESTS

HOME ADDRESS (NOT P.O. BOX) ( ) YRS. PAID ON HOME

HOMESTEAD ❑ YES MOBILE HOME ❑ YES RENT ❑YES

BAL. OWED $ TAX ASSESSED VALUE $ MARKET VALUE $

1ST CAR YR. MODEL VALUE $

2nd CAR YR. MODEL VALUE $

BOAT VALUE $

MOTOR HOME VALUE $

OTHER PROPERTY VALUE $

RENTAL ❑ VACANT LAND ❑ BAL. OWED VALUE $

BANK NAME / CREDIT UNION ACCT # AVERAGE CHECKING/SAVINGS BALANCE $

BANK NAME / CREDIT UNION ACCT # AVERAGE CHECKING/SAVINGS BALANCE $

C.D.'S - BANK NAME BALANCE BALANCE $

STOCKS / BONDS - BROKER FIRM IRA/ TRUSTS / 401k USTS / 401k LIST OTHER ASSETS (ATTACH ADD'L SHEETS IF NECESSARY) VALUE $

VALUE $

VALUE $

THE VALUE OF ALL ASSETS LISTED ABOVE..... TOTAL $

Monthly Living Expenses

PAYMENT TO	FOR	TOTAL AMT OWED	AMT DUE EACH MONTH	AMT PAST DUE
MEDICAL	FLORIDA MEDICAL CLINIC	$	$	$
"	HOSPITALS (ALL)	$	$	$
"	DOCTORS (ALL)	$	$	$
"	MEDICATION	N/A	$	N/A
HOUSING	HOME MORTGAGE	$	$	$
"	2ND MORTGAGE	$	$	$
"	PROPERTY TAX	$	$	$
"	RENT	N/A	$	$
"	MOBILE HOME LOT	N/A	$	$
FOOD	GROCERIES / SCHOOL / WORK / LUNCHES	N/A	$	N/A
UTILITIES	ELECTRIC / GARBAGE / GAS / WATER	N/A	$	$
"	PHONE / CELLULAR / BEEPER	N/A	$	$
TRANSPORTATION	1ST CAR	$	$	$
"	2ND CAR	$	$	$
"	GASOLINE	N/A	$	$
LOANS	BOAT / MOTOR HOME	$	$	$
"	BANK / CREDIT UNION / FINANCE CO / LOANS	$	$	$
CHARGE CARDS	SUM OF *ALL* CREDIT CARDS	$	$	$
FAMILY	DAY CARE / BABY-SITTERS	N/A	$	$
"	CHILD SUPPORT/ALIMONY EXPENSE	$	$	$
"	SCHOOL TUITION	$	$	$
INSURANCE	AUTO INSURANCE	$	$	$
"	MEDICAL INSURANCE	$	$	$
"	LIFE INSURANCE	$	$	$
"	RENTERS INSURANCE	$	$	$
ENTERTAINMENT	ALCOHOL / TOBACCO	N/A	$	N/A
RECREATION	CABLE TV / SATELLITE SERV / DSS / VIDEOS	N/A	$	$
"	IRS /JUDGMENTS / LIENS / OTHER	$	$	$
DONATIONS	CHURCH/SYNAGOGUE/OTHER	N/A	$	N/A
	TOTALS			

AGREEMENT

Please read before signing. I CERTIFY the information I have provided is true and accurate to the best of my knowledge. I will make application for ANY and ALL ASSISTANCE which may be available through federal, state, local government and private sources to help pay this bill and will take all action necessary to obtain assistance from the above sources. I understand that if I do not cooperate with Florida Medical Clinic within 45 days from the date of service in requesting ANY additional Information, my application may be denied for possible financial assistance. I hereby grant permission and authorize any accredited agent of the Department of Children and Families to disclose to Florida Medical Clinic ALL information regarding the status of my Medicaid application and if the application Is not approved, the reason for disapproval. I will ASSIGN to Florida Medical Clinic ALL FUNDS received from the above sources, which are provided to help with this BILL. I, on my own behalf, and for my immediate family member(s), authorized representative(s), physician(s), counselor(s) (including clergy), and attorney(s), agree to hold and maintain In strictest confidence any written communications and/or oral discussions between me and Florida Medical Clinic regarding matters relating to services provided to me by Florida Medical Clinic. 1 understand that the information which I submit Is subject to verification by Florida Medical Clinic, Including credit reporting agencies, and subject to review by FEDERAL and/o STATE AGENCIES and others as required. I AUTHORIZE my employer to release to Florida Medical Clinic proof of my income. I UNDERSTAND that if any information I have given proves to be untrue, Florida Medical Clinic will re-evaluate my financial status and take whatever action becomes appropriate. Should additional information become available, Florida Medical Clinic reserves the right to reconsider this decision not limited to first or third party recovery settlement or inheritance. Florida Statute s.817.50 (1) Whoever shall, willfully and with Intent to defraud, obtain or attempt to obtain goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in s.775.082 or 0.775-083.

Signature: _____