Community Cancer Center

Patient Financial Assistance Policy

If you are unable to pay for you radiation therapy services, due to limited financial resources, you may qualify for our Financial Assistance program. This program only applies to radiation therapy services provided by the Community Cancer Center and is only valid for 6 months at which time a new application will have to be completed. ***It does <u>not</u> apply to copays or co-insurance for office visits*.**

General Guidelines:

- Any patient can apply for assistance on their financial responsibility after all other payment resources are exhausted including Medicare, private insurance or personal assets.
- For consideration of financial hardship, the patient will be asked to complete a financial disclosure and provide proof of income. Other types of documentation, such as expenses, bank statements or tax forms, if requested, must also be provided for consideration.
- Discounts are based on the Federal Poverty Guidelines income limits and number of persons within the household.

After discounts are applied, remaining balances may be paid on a monthly payment plan not to exceed 36 months.

Financial Assistance Determination Process:

All patients will meet with the Director of Financial Operations, usually within the first week of radiation therapy to discuss financial obligations. If the patient is determined to be eligible for financial assistance, the patient or caregiver will be given a Financial Disclosure to complete.

- Possible qualifying circumstances may include:
  - Patient is uninsured and has no ability to pay.
  - Patient is unemployed with no foreseeable income in the near future.
  - Patient has limited income.

Review Criteria:

The review committee will review the Application for Financial Assistance based on the following criteria:

- Household Income: All income must be reported and verified using payroll stubs and/or the most recent tax return. Income is defined as all income for household of all persons over the age of 18 who reside in the household. Social security, pension payments, rent, and spousal or child support are considered income.
- Expenses: Reviewed for reasonableness and necessity. Additional information may be requested regarding expenses out of the ordinary.
- Assets: All cash or non-cash assets owned by a member of a household that can be converted to cash including:
  - Checking, savings or money market accounts;
  - Retirement plans;
  - Equity in real estate other than the primary residence;
  - Stocks, bonds, treasury bills, or certificates of deposits;

  - Vehicles other than primary source of transportation; and
  - Lump sum or one-time receipt of funds including, but not limited to, cancer policies, inheritances, lottery winnings and settlements.
- Persons in Household: The number of individuals living in the household will be reviewed in relation to income.
- Employment Status: Employment status will be considered. If it appears that applicant has the likeliness of future earnings to meet the financial responsibility within a reasonable period of time, then application may be denied or reviewed at a future time.
- Financial Obligations: Financial obligations including mortgage and other loan payments will be reviewed. Reasonable and necessary obligations will be considered.
- Other Medical Expense: Medical expenses and prescriptions from all providers will be considered.
- The refusal of an applicant to provide reasonable information requested will result in a denial of financial assistance.

Final Determination:

Final determination is based on either income and assets, or the combination of income, assets, and reasonable and necessary expenses. Determination based on a sliding scale using the HHS Poverty Guidelines found at HealthCare.gov . Current guidelines are shown below:

HHS POVERTY GUIDELINES FOR 2019

The 2019 poverty guidelines are in effect as of January 11, 2019.
Federal Register notice forthcoming. Publication is delayed due to temporary closure of federal offices.

2019 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA	
PERSONS IN FAMILY/HOUSEHOLD	POVERTY GUIDELINE
For families/households with more than 8 persons, add $4,420 for each additional person.	
1	$12,490
2	$16,910
3	$21,330
4	$25,750
5	$30,170
6	$34,590
7	$39,010
8	$43,430

Collection of Patient Responsibility after Financial Assistance Write-off:

- Balances remaining after financial assistance may be paid in monthly installments with a payment due by the end of each month.
- Account balances that remain unpaid after financial assistance will be subject to the collection policy and practices of the Community Cancer Center. If the account is sent to an outside agency for collection, all financial assistance discounts will be reversed.

Community Cancer Center

Application for Financial Assistance

Name: _____ SS#:_____ Birthdate: _____

Address: _____ Telephone: _____

Former Address: _____

(If at present address less than two years)

Marital Status: ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Spouse's Name:_____ SS#:_____

Number in Household: _____ Number of Dependent Children at Home: _____ Ages: _____

MONTHLY HOUSEHOLD INCOME PLEASE PROVIDE PROOF OF INCOME

Name of Person Employed (or receiving SSI)	Name of Employer (Please indicate if SSI)	Length of Employment	Monthly Gross $	Monthly Net $
			$	$
			$	$
			$	$

All Other Income Not Listed Above (List Sources):

$	$	
$	$	
TOTAL MONTHLY INCOME	$	

MONTHLY LIVING EXPENSES

	Monthly Payment
Home: ❒ Own ❒ Rent _____	$
Automobile: Gas _____ Maintenance & Repairs _____	$
Food & Household Items: _____	$
Utilities: Gas _____ Electricity _____ Water _____ Phone _____	$
Insurance: Life _____ Health _____ Auto _____ Other _____	$
Medications: _____	$
Miscellaneous (Clothing, Child Care, School, Etc.): _____	$
TOTALS from Page 2: A _____ B _____ C _____	$
TOTAL MONTHLY LIVING EXPENSE	$

ASSETS CASH AND INVESTMENTS

Bank and Branch	Type of Account	Account Balance
		$
		$
		$
	TOTAL ASSETS	$

CHARGE CARDS MASTERCARD, VISA, DEPARTMENT STORES

Bank and Branch	Account Balance		Monthly Payment
		$	
		$	
		$	
		$	
		$	
TOTAL CHARGE CARD EXPENSE (A)		$	

OTHER CREDITORS AUTO/RV LOANS, ETC.

Bank and Branch	Account Balance		Monthly Payment
		$	
		$	
		$	
TOTAL OTHER CREDITORS EXPENSE (B)		$	

MEDICAL CREDITORS

Provider Name	Account Balance		Monthly Payment
		$	
		$	
		$	
		$	
		$	
TOTAL MEDICAL CREDITORS EXPENSES (C)		$	

The above information is warranted to be true.

I hereby authorize any Credit Bureau or other investigative agency employed by Community Cancer Center to investigate the references herein listed or statements of other data obtained from me or from any other person pertaining to my credit and financial responsibility.

Date: _____ Signature of Applicant: _____

FOR OFFICE USE ONLY:

Estimated Patient Responsibility: $_____

Discount Approved/Denied: ED: _____ Med Director: _____ ❑ Denied

❑ Approved Based on Income _____% ❑ Approved Based on Income/Expense _____%

Patient informed by: ❑ Letter ❑ Phone ❑ In Person By _____on _____(Date)