FINANCIAL ASSISTANCE POLICY

Policy: It is the policy of Community Hospital, Inc. and the Patient Accounts department to provide uninsured (self-pay) and/or financially indigent patients assistance in obtaining medical care.

Financial Hardship Application Procedures:

An application for Financial Hardship will be taken by referral, patient/guarantor request, or discovery of need.

All claims must be filed against any/all patient/guarantor owned insurance policies and paid directly to Community Hospital, Inc. before we will consider any portion of the balance for the Financial Hardship Policy.

The patient/guarantor must present written verification of his/her income and other resources available for the previous twelve (12) months and the projected upcoming twelve (12) months or of any other household member that contributes a specified amount on a regular basis to the livelihood of the entire household.

If there is a considerable amount of time between the date of service and the date the application was requested, the patient/guarantor will be required to provide Community Hospital, Inc. with verification of his/her income and other resources available at the time the service was rendered.

The application must be completed, signed by the patient/guarantor, and returned to the Patient Accounts office in ten (10) business days from the date on the letter accompanying the application.

Copies of the previous year's income tax returns, signed and dated by the preparer must be submitted with the application.

All other sources of money or other assets must be noted on the application.

Applications are only valid for (3) months after the application is completed.

For all emergency medical conditions and labor, we will follow the applicable EMTALA, Federal, and State guidelines as applicable.

Certain factors may contribute to the approval or denial of the application.

Community Hospital, Inc. will be granted the authority by patient/guarantor to verify the account balances in any bank or savings and loan institution.

The patient/guarantor will be asked to provide to Community Hospital, Inc. his/her physician's signature as verification of inability to work during a specified period of time prior to or after upcoming services at Community Hospital, Inc.

The patient/guarantor will be asked to provide to this facility a written statement from his/her employer as to whether or not employment will be available to this patient/guarantor and the estimated amount of projected yearly income when his/her physician allows him/her to re-enter employment.

When the patient's/guarantor's yearly family income for the past twelve (12) months exceeds the Federal Poverty Income Guidelines plus 200%, but the patient/guarantor does not anticipate returning to work within ninety (90) days of the date of discharge, the projected family income becomes the determining factor.

The Approval/Denial process is as follows:

The Managers and Supervisors will review the applications and approve or deny them based on the guidelines set forth in the policy. All applications whether approved or denied will be forwarded to the Supervisor of Patient Accounts for a final review.

Applicants will be notified by phone, mail, or in person of approval or denial.

If the application is denied, any account balances will be processed through normal collection procedures.

Community Hospital Inc.
805 Friendship Road
Tallassee, Alabama 36078
(334) 283-6541

Dear Valued Customer:

Thank you for choosing Community Hospital, Inc. for your healthcare needs. Your request for Financial Hardship Services has been received by our office. Community Hospital, Inc.'s Financial Hardship program is available to assist those patients determined to be financially indigent without regard to race, color, creed, or national origin. Eligibility for this service is income-based. In order to process your application, the following documents will be needed to ensure criteria requirements are met in your situation:

1. Verification of all income, such as a W-2, Social Security and/or other governmental checks, food stamps, pensions, child support, etc.

2. An official copy of your most recent income tax return signed and dated by preparer if another person completed your return.

3. Three most recent bank statements.

We have enclosed an application for you to complete and return when you come to our office, along with the information requested above. It is very important that we receive this completed application and information back in our office within ten (10) working days from the above date. **If the required information is not received within the ten (10) day time limit, your application will be discarded and you must reapply again.** In addition, your account may be subject to our normal collection procedures. Please note that all applications to this program are subject to credit check for verification of information. **Any false information provided, will disqualify your application and will disqualify you from applying to the program in the future.**

You will be notified as to whether your application has been approved or denied. If your application has been denied you will need to set up acceptable payment arrangements on your account(s). If your application is approved you will be notified as to the amount of the discount you will receive and what amount you will need to set up payment arrangements on. Once you have completed the application and gathered the required documents, please call (334) 283-3736 or (334) 283-6541 and ask for the financial assistance representative to arrange an appointment to finalize the application process.

Sincerely,

Patient Accounts

Request for Financial Hardship

Community Hospital, Inc.
Tallassee, AL

Approved:_____ Denied:_____ Date:_____

Comments:_____

_____

Date of Request:_____ Patient Accounts Representative:_____

I would like to apply for the Financial Hardship Policy, under the provisions set forth by Community Hospital, Inc.

1. Applicant Name:_____

   Patient Name: _____
   First Middle Last

   Address:_____
   Number & Street City State Zip

   Telephone: Residence ( )_____ Business ( )_____

   Employer/Employer's Address:_____

2. List all members of your household (including self):

Name	Age	Relation/Occupation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Income:

	Total/Monthly:	Total/Yearly:
Wages	$_____	$_____
Other	$_____	$_____

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4. Admitting Diagnosis:_____

5. Public Assistance:

A. Have you applied for Medicaid or other public assistance?_____
B. What was the approximate date of your application?_____
C. What response have you received?_____

5. List Patient Account Numbers & Date(s) of Service:

New	Add	Account #	Date of Service	Account Balance

I hereby request that my application for Financial Hardship be reviewed by Community Hospital, Inc. Patient Financial Services. I understand that the information submitted herein is subject to verification by Community Hospital, Inc. I also understand that if the information that I have submitted is determined to be false, it will constitute fraud. Such a determination will result in denial of Financial Hardship, and I will be liable for charges for services provided.

_____ _____
Signature (Patient) Signature (Requesting Person)

_____
Date

Additional Comments:

_____
_____
_____
_____
_____