

Sample Financial Hardship Policy

Practice Name:

POLICY EFFECTIVE DATE: January 1, 2003

Purpose:

This Policy is intended to establish criteria to determine the appropriateness of waiving or lowering co-pays, co-insurance and/or deductible amounts and to assure that any such waivers or reduced payments that may occur are authorized by this Policy.

Policy:

Our practice will not waive or discount out-of-pocket amounts, and/or deductibles and/or co-insurance unless authorized by this Policy.

Guidelines:

1. Waiver Policy. It is the policy of this practice to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. However, if we determine that the patient's financial situation meets the criteria in this policy and that a patient is financially unable to pay any out-of-pocket amounts, our practice may waive or lower such amounts.

2. Other Policies Under no circumstances will our practice engage in any of the following practices with respect to the waiver or lowering of co-insurance and/or deductibles:

- a. Waive or lower co-insurance and deductibles that do not meet the requirements outlined in our Policy.
- b. Advertise, or in any way communicate to the general public that payments from private insurance, Medicare or Medicaid will be accepted as payment in full for health care services provided by our practice, or advertise or otherwise communicate to our patients or to the general public that patients will incur no out-of-pocket expenses.
- c. *Routinely* use financial hardship forms which state that the patient is unable to pay co-insurance and deductible amounts.
- d. Charge Medicare beneficiaries or private insurance beneficiary's different amounts than those charged to other persons for similar services.
- e. Fail to collect co-insurance and deductibles from a specific group of patients for reasons unrelated to indigence or managed care contracting, (to obtain referrals or to induce patients to seek care in my practice vs. another provider's practice who does not waive co-pays and/or deductibles).

- f. Accept “insurance only” or TWIP (take what insurance pays) as payment in full for services rendered.
- g. Fail to make a reasonable collection effort to collect a patient’s balance.

3. Determination of Financial Need

- a. Decisions to waive or reduce any co-insurance and/or deductible amounts owed by a patient will be made on a **case-by-case** basis. To ensure that decisions to waive or reduce co-insurance and/or deductible amounts are documented and based upon uniform objective criteria, each patient who desires a waiver or reduction of any co-insurance and/or deductible amount must complete the attached confidential Financial Worksheet and submit the completed worksheet together with a copy of the responsible party’s most recent W2 form or most recent federal tax return. The information on this worksheet will be compared to our policies to determine eligibility for waivers or lower payments.
- b. Decisions to waive or lower co-insurance and deductible amounts are based upon the financial information supplied by the patient in the Financial Worksheet and the W2 and/or federal tax return.
- c. Our practice reserves the right to modify the criteria considered for a waiver or payment reduction without notice.
- d. Our practice reserves the right to decline to grant waivers or payment reductions to patients without explanation.

4. Criteria considered to determine financial hardship

- a. Patient’s or family’s income in relationship to 200% of National Poverty level
 - 1. 100% waiver of all deductibles and co-pays if family income is equal to or less than 200% of National Poverty level. (See next page.)
- b. Patient’s or family’s discretionary income (total monthly income less total monthly expenses)
 - 1. Payment plans will be established for patients whose discretionary income meets the following schedule:

Monthly Discretionary Income	Monthly Payment Plan
\$0-350	\$25.00
\$351- \$450	\$35.00
\$451-\$500	\$50.00

National Poverty Level

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	\$10,830	\$13,530	\$12,460
2	14,570	18,210	16,760
3	18,310	22,890	21,060
4	22,050	27,570	25,360
5	25,790	32,250	29,660
6	29,530	36,930	33,960
7	33,270	41,610	38,260
8	37,010	46,290	42,560
For each additional person, add	3,740	4,680	4,300

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199-4201

SAMPLE CONFIDENTIAL FINANCIAL WORKSHEET

NAME OF PRACTICE

Patient Name: _____

Address: _____

Telephone: _____

Responsible Party: _____

Address: _____

Telephone: _____

PLACE OF EMPLOYMENT; FAMILY SIZE

Patient employment: _____

Number in Household: _____

Parent/Spouse: _____

Number in School: _____

Other Dependents: _____

NET INCOME MONTHLY (Attach most recent W2 and/or most recent Federal tax return)

Patient's Income: _____

Spouse's Income: _____

Father's Income (if minor): _____

Mother's Income (if minor): _____

NET EXPENSES MONTHLY

Rent/House Payment: _____

Car/Truck Payments: _____

Car Insurance: _____

Utilities (electric, phone, gas, water): _____

Food/clothing: _____

Credit card payments: _____

Loan payments (Bank, credit company, school loans): _____

Health/Dental Insurance: _____

Child care: _____

Child Support: _____

Life Insurance: _____

Social Security: _____

Property Insurance: _____

Pension: _____

Property Tax: _____

SSI/Disability: _____

Medical Fees (Dr, Rx, Hospital): _____

Food Stamps: _____

Other Income: Yes No

Other: _____

Explain

TOTAL MONTHLY INCOME \$ _____

TOTAL MONTHLY EXPENSES \$ _____

Total Monthly Discretionary Income \$ _____

You certify that the above information is true and accurate and that this application is made to allow our practice to determine your eligibility for reduced out of pocket health care costs.

If any of the information that you have given proves to be untrue, we will promptly reevaluate your financial status and take action necessary to collect on your account.

Signature of patient or parent or legal guardian if patient is a minor

_____ date _____

Name of Insurance Company _____

Policy Number _____

Phone Number _____

Applicant approved or denied for financial hardship assistance.

APPROVED

DENIED

Ded _____ COINS _____ Other _____

Authorized Signature: _____ Date _____