NOTICE OF AVAILABILITY OF COMMUNITY CARE & FINANCIAL ASSISTANCE PROGRAM

Part of the Heart of America Medical Center's mission statement is to provide medical care regardless of the patients' ability to pay. Community care is available based on the following guidelines:

1. HAMC services that are available for community care are hospital acute care inpatient, hospital outpatient services, clinic services and swing bed. To qualify for community care, the applicant must first exhaust all forms of reimbursement from insurance and government programs.

2. Patients who are eligible to qualify for HAMC community care program will receive community care after all third party payments have been exhausted.

3. The HAMC will provide community care without discrimination to all persons who are eligible for services and who request community care in a proper manner. (Poverty guidelines listed on reverse side)

4. Notice of Availability of Community Care will be presented to each patient prior to the rendering of services or in an emergency situation, as soon as it is considered appropriate. The Community Care Application Form must be completed in its entirety and submitted to the Business Office. Written verification of the information must also be submitted with copies of one or more of the following documentation for the three months preceding application date:

   a. Paystubs showing earnings or a written release for verification of wage information from his/her employer.
   b. If self-employed, itemized income and expenses for business.
   c. Verification from public welfare agencies (food stamps, childcare assistance, TANF, etc.)
   d. Verification of unemployment compensation or workers compensation.
   e. Income tax returns from the prior year including W-2 forms.

If mailing, please address to: Heart of America Medical Center
Attn: Business Office
PO Box 1826
Scottsbluff, NE 69363-1826

5. The HAMC will render a conditional or final determination of eligibility upon the receipt of a properly signed and documented application. The reasons for a conditional determination of eligibility will be properly explained on the application. Applicant has two (2) weeks from date of notification to submit additional information needed or look back period will be changed. Approved final determination of eligibility may be revoked if upon further investigation, third party payment is possible.

Heart of America Medical Center Policy Procedure
Community Care Program

2018 Federal Poverty Income Guidelines (FPIG)

Based upon	200% FPIG	225% FPIG	250% FPIG	275% FPIG	300%FPIG	>300%FPIG
If your Family Size is:	**And your Annual Income is at or**					
	below:	**below:**	**below:**	**below:**	**below:**	**above:**
1	$24,280	$27,315	$30,350	$33,385	$36,420	$36,420
2	$32,920	$37,035	$41,150	$45,265	$49,380	$49,380
3	$41,560	$46,755	$51,950	$57,145	$62,340	$62,340
4	$50,200	$56,475	$62,750	$69,025	$75,300	$75,300
5	$58,840	$66,195	$73,550	$80,905	$88,260	$88,260
6	$67,480	$75,915	$84,350	$92,785	$101,220	$101,220
7	$76,120	$85,635	$95,150	$104,665	$114,180	$114,180
8	$84,760	$95,355	$105,950	$116,545	$127,140	$127,140
For each additional person, add	$4,320					
Your benefit would be:	**100%**	**80%**	**60%**	**40%**	**20%**	**0%**

Applicants will not be required to spend down their assets to qualify for community care.

If you think you may be eligible for community care services, complete the attached application.
For additional information, please contact the Business Office at 701-776-5261.

ccare2
9/24/2018

HEART OF AMERICA MEDICAL CENTER - COMMUNITY CARE PROGRAM APPLICATION

Name: ____
First M.I. Last

Address:____
Mailing City/State Zip Code

____
Social Security # **Date of Birth** **Phone #**

____
Occupation **Employer** **Employers Phone #**

Type of Service Rendered/Requested__________________________________
and/or **Date of Service to be covered**________________________________

<u>Services not eligible for the Care program</u> include, but are not limited to: Services billed by separate entities (i.e. Radiologist, etc.) and balances that have been turned over to collections.

Complete detail on back of form.

I hereby request that Heart of America Medical Center (HAMC) make a determination of my eligibility for community care program services at HAMC. I certify that the information is true and accurate to the best of my knowledge and I understand that if the information I submit is determined to be false, it will result in a denial of community care program services. All alternative payment resources must have been exhausted (including Medicaid, Medicare, Insurance, etc.) which may be available for payment of my charges. I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges.

Date of Request _______________**Applicant Signature** _______________________________

<u>ELIGIBILITY DETERMINATION</u> (For Office Use Only)

Date Application Received: ______________________ Income Verified: Yes________No ______

Type of Verification: ____
Last 3 months x 4 AGI on tax return

Family Size ___________ Total Household Income ________________

_______The applicant is approved for the Community Caring Program at ____________% allowance.

The amount that qualified for consideration was $_________________.

Your Caring Program approval will expire on ______________________. At that time, if you still need financial assistance to meet your healthcare needs you may reapply for the Community Care Program.

_______In order to make a determination on your application, please provide me with the following:

_______The applicant's request for Community Care services has been denied for the following reason(s):

Date of Conditional Determination ______________ Date of Final Determination ____________
Date Applicant Notified ______________Approved by ______________________________

ccare3

INCOME: **1) List total gross income for your household below for the last 3 months. (List total net income if self employed.)**
2) Provide us with verification of that income.
3) Provide a copy of your most recent Federal Income Tax return (or complete a Form 4506-T to verify that you did not file Federal Income Tax)

	Self	Spouse/Supporting Household Member
Wage Income.................	______________	______________
Farm or Self-employment......	______________	______________
Public Assistance (Food Stamps, TANF, etc)	______________	______________
Social Security.............	______________	______________
Unemployment Compensation....	______________	______________
Worker's Compensation........	______________	______________
Strike Benefits.............	______________	______________
Alimony.....................	______________	______________
Child Support...............	______________	______________
Military Family Allotments...	______________	______________
Pension.....................	______________	______________
Income from Dividends, Interest, Rent........	______________	______________
Other......................	______________	______________
Subtotals:	______________	______________

TOTAL: ____________________

HOUSEHOLD OCCUPANTS:

Name	**Relationship**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

HEALTH INSURANCE: Does any member of your household have any type of health insurance such as Blue Cross, Medicare, Medicaid or commercial insurance?

_____________ Yes___________ No

If yes, please provide a copy (front & back) of your insurance card.

ccare4