

## Sample Financial Hardship Policy

Health Department Name: \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_

### 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:

This health department will not waive or discount out-of-pocket amounts, and/or deductibles and/or coinsurance unless authorized by this Policy.

### Guidelines:

#### 1. Waiver Policy.

It is the policy of this health department 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 health department may waive or lower such amounts.

#### 2. Other Policies

Under no circumstances will our health department 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 health department, 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 or private insurance beneficiaries 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 this health department 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. This health department reserves the right to modify the criteria considered for a waiver or payment reduction without notice.
- d. This health department 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 the current 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.
- 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:

<b><u>Monthly Discretionary Income - Monthly Payment Plan</u></b>	
\$0-350	\$25.00
\$351- \$450	\$35.00
\$451-\$500	\$50.00

National Poverty Level  
2021 HHS Poverty Guidelines\*

States & D.C.	Persons in Family	48 Contiguous
	1	\$12,880
	2	\$17,420
	3	\$21,960
	4	\$26,500
	5	\$31,040
	6	\$35,580
	7	\$40,120
	8	\$44,660

For Each Additional Person - Add **\$4540**

*\*Source: U.S. Department of Health & Human Services*

**Sample Confidential Financial Worksheet**

**Name of Health Department:** \_\_\_\_\_

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:

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Loan payments:

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*(Bank, credit company, school loans)*

Health/Dental Insurance:

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Child care:

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Child Support:

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Life Insurance:

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Social Security:

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Property Insurance:

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Pension:

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Property Tax:

---

SSI/Disability:

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Medical Fees :

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*(Dr, Rx, Hospital)*

Food Stamps:

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Other Income: Yes No

Other:

\_\_\_\_\_

Explain:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Total Monthly Income**

\$ \_\_\_\_\_

**Total Monthly Expenses**

\$ \_\_\_\_\_

**Total Monthly Discretionary Income**

\$ \_\_\_\_\_

**Certification:**

You certify that the above information is true and accurate and that this application is made to allow this health department 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 re-evaluate 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.

Circle One:    APPROVED            DENIED

Authorized Signature:

\_\_\_\_\_

Date

\_\_\_\_\_

*Note: The information included in this section is presumed current at press time. Check the source for the latest versions and information relating to documents. The user is solely responsible for any documents utilized.*