HOUSTON HEALTHCARE

Financial Assistance Application

In order to qualify for Financial Assistance based on ***income***, annual household income must be less than or equal to 300% of the Federal Poverty Guidelines. The most a patient will pay is the amount generally billed (AGB) to insured patients as defined in the financial assistance policy.

The 2024 Federal Poverty Guidelines are listed below:

		Less than or equal to					
Household size	2024 Federal Poverty Guideline	125% of Federal Poverty Guidelines	200% of Federal Poverty Guidelines	225% of Federal Poverty Guidelines	250% of Federal Poverty Guidelines	275% of Federal Poverty Guidelines	300% of Federal Poverty Guidelines
1	15,060	18,825	30,120	33,885	37,650	41,415	45,180
2	20,440	25,550	40,880	45,990	51,100	56,210	61,320
3	25,820	32,275	51,640	58,095	64,550	71,005	77,460
4	31,200	39,000	62,400	70,200	78,000	85,800	93,600
5	36,580	45,725	73,160	82,305	91,450	100,595	109,740
6	41,960	52,450	83,920	94,410	104,900	115,390	125,880
7	47,340	59,175	94,680	106,515	118,350	130,185	142,020
8	52,720	65,900	105,440	118,620	131,800	144,980	158,160
Maximum amount individual is responsible for paying		$0.00	Lesser of $150.00 or AGB	The greater of $150.00 or 15% of AGB, unless AGB is less than $150.00 then AGB.	The greater of $150.00 or 30% of AGB, unless AGB is less than $150.00 then AGB.	The greater of $150.00 or 45% of AGB, unless AGB is less than $150.00 then AGB.	The greater of $150.00 or 60% of AGB, unless AGB is less than $150.00 then AGB.

In order to qualify for Financial Assistance based on ***medical expenses***, medical expenses incurred within the preceding 90 days must be greater than 15% of annual household income.

A completed application may be hand delivered to any Financial Counselor located in the Patient Financial Services office at 233 North Houston Road, Suite 230, Warner Robins, GA 31093. An application can also be mailed to the following address:

Houston Healthcare
Attn: Financial Counseling
P.O. Box 2886
Warner Robins, GA 31099

Contact Information:
Email: hhc-financialcounseling@hhc.org
Phone: (478) 329-3456
Fax: (478) 322-2579

Financial Assistance Procedures:

1. When an Application is received for Financial Assistance, it will be reviewed for completeness, which includes all supporting documentation.

   APPLICATIONS CAN NOT BE PROCESSED UNTIL ALL SUPPORTING DOCUMENTATION IS PROVIDED.

2. If it is determined that the Application is incomplete, Houston Healthcare will take the following actions:
   a. Suspend any collection actions against the patient/Guarantor.
   b. Provide the patient with a written notice that describes the additional information or documentation the patient must submit to complete his or her Application.
   c. Provide the patient with at least one written notice that informs the patient/guarantor about the collection actions including any extraordinary collection actions that may be initiated or resumed if the Application is not completed or if the amount due is not paid within 30 days from the date of the notice.
   d. If all supporting documentation is not submitted or the amount due is not paid within 30 days of the written notice as described in the preceding paragraph, the request for Financial Assistance will be denied and the account will remain in the billing cycle. A new Application may be submitted if the date of the Application is within 240 days after Houston Healthcare issues the first post discharge billing statement to the patient.
3. Once a completed Application has been received and reviewed, the Financial Counselor will make a recommendation for approval or denial of the Application. The Application is given to the appropriate individuals based on the account balance and amount of the Financial Assistance discount requested for approval. Houston Healthcare will render a decision in no more than five (5) working days from the receipt of a completed Financial Assistance Application.
4. The patient will be notified in writing of Houston Healthcare's decision to provide Financial Assistance.

Financial Assistance Application Guidelines:

All requests for Financial Assistance must be submitted using Houston Healthcare's Financial Assistance Application. The Application must be completed in its entirety and all supporting documentation attached to the Application.

1. The application period during which Houston Healthcare will accept and process a Financial Assistance Application ends on the 240th day after Houston Healthcare issues the first post discharge billing statement to the patient.
2. Applicant shall submit the following supporting documentation, if applicable, with a completed Application:
   i. Proof of income – IRS Form W-2, the most recent federal income tax return, pay stubs covering the last 90 consecutive days as of the date of application, proof of Social Security, unemployment receipts, investment income, alimony, worker's compensation, rental/royalty income, retirement income and any other documentation that supports household income as defined in the financial assistance policy.
   ii. Checking and savings account statements for the most recent 3 months.
   iii. If the annualized Household income has decreased 10% or more than the most recent federal income tax return, the applicant must submit a written explanation for the decrease in annual Household income.
   iv. Proof of medical expenses - all billing statements for medical expenses incurred within the last 90 days.
   v. Unemployment denial letter

vi. Any additional documentation the applicant deems necessary to support their application for Financial Assistance.

3. Falsifying information on the Application will be grounds for denying or revoking Financial Assistance. Falsifying an Application includes, but is not limited to, failure to disclose assets.
4. Applicant shall identify all known third party payment sources for services rendered. Applicant shall cooperate with Houston Healthcare in filing of claims and collection of reimbursement from all third party payment sources. Failure to cooperate will be grounds for denying Financial Assistance.
5. Applicant shall cooperate in the application for Financial Assistance from other sources, such as Medicaid and other programs. Failure to cooperate will be grounds for denying Financial Assistance.

Definitions:

1. **Household** – The household consists of the applicant, spouse and all legal dependents as allowed by the Internal Revenue Service. If the applicant is a minor or legal dependent for income tax purposes, the household will include parent(s), legal guardian(s) and/or the taxpayer claiming the patient as a dependent for income tax purposes.

2. **Household Income** – The combined annual income of all members within the Household, as previously defined which includes the patient or Guarantor. Combined annual income will be calculated by annualizing documented income over the last ninety (90) consecutive days. For the purposes of determining financial eligibility for Financial Assistance, income includes all monies received before taxes from all sources, including, but not limited to, estate payments, net rental income, alimony, military family allotments, employee pensions or retirement plans, military retirement pay, veteran's payments, self-employment income, royalties, Social Security payments, railroad retirements, unemployment compensation, regular insurance or annuity payments, interest income, private pensions, workers compensation benefits and employment wages. The Hospital will require supporting documentation to be submitted with the paper Application. Income does not include Medicare, Medicaid, food stamps, heat assistance funds, school lunches or housing assistance, employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, loans, need-based assistance from non-profit organizations, child support or foster care payments, or disaster relief assistance.

3. **Allowable Medical Expenses** – The total Household medical bills that would qualify as deductible medical expenses for Federal income tax purposes without regard to whether the expenses exceed the IRS required threshold for taking the deduction that have been incurred within ninety (90) days prior to date of service at Houston Healthcare. Paid and unpaid bills may be included.

4. **Guarantor (Responsible Party)** – Individual other than the patient who is responsible for payment of the patient's bill.

HOUSTON HEALTHCARE

Financial Assistance Application

MR Number & Account Number to be completed by hospital personnel	MR Number	Hospital	Account Number	
Patient's First Name:	Patient's MI:	Patient's Last Name:	Date of Birth:	Total # of Household Members:
Address:		Patient's Social Security No:	Home Phone / Cell Phone	
City / State/ Zip:		Responsible Party Name (First, MI, Last):		

List ALL household member names	Date of Birth	Social Security Number	Relationship to Patient	Monthly Income
1.		- -		$
2.		- -		$
3.		- -		$
4.		- -		$
5.		- -		$
6.		- -		$

Monthly Income		Amounts Reported on Last Tax Return	
Wages, salaries, tips, etc. Attach pay stubs covering last 90 consecutive days	$	Wages, salaries, tips, etc. Attach Form(s) W-2	$
Investment Income - Interest, Dividends, & Capital Gains or (Capital Loss)	$	Investment Income - Interest, Dividends, & Capital Gains or (Capital Loss)	$
Alimony	$	Alimony	$
Business Income or (loss)	$	Business Income or (loss)	$
Social Security	$	Social Security	$
Unemployment	$	Unemployment	$
Worker's Compensation	$	Worker's Compensation	$
Rental income, royalties, partnerships,	$	Rental income, royalties, partnerships,	$
Retirement Income	$	Retirement Income	$
Farm Income	$	Farm Income	$
Other:	$	Other:	$
Total Monthly Income (before taxes)	$	**Total Income Per Federal Tax Return**	$

I certify that the information provided above is an accurate and true representation of my financial information. I also certify that there is not additional insurance coverage for this patient other than what was listed at time of registration. I understand that providing false information will result in denial of the application for any type of financial assistance through Houston Healthcare. If I am entitled to any action against or settlement from third party payers, I will take any action necessary or requested by Houston Healthcare to obtain such assistance and will assign to Houston Healthcare. Upon receipt of any settlement from third party payers, I will pay Houston Healthcare all amounts recovered up to the total of the outstanding balance on the account. My failure to apply for such assistance or to follow through with the application process or take those actions reasonably necessary or requested by Houston Healthcare will result in the denial of this application. I also authorize Houston Healthcare to check my credit history through the credit bureau, if deemed appropriate.

Signature of Patient (Responsible Party)

Date

Tax Information

In the event that you have not filed taxes for the previous year, please fill out and sign below: (please include spouse's name if applicable)

I, _____, have not and will not file taxes for the year _____

_____ _____
Signature Date

_____ _____
Spouse's signature (if applicable) Date

Checking and Savings Account Information

In the event that you do not have a Checking or Savings account, please fill out and sign below: (please include spouse's name if applicable)

_____ I do not have a Checking account. _____I do not have a Savings account.

_____ _____
Signature Date

_____ _____
Spouse's signature (if applicable) Date

Support Document

In the event that you do not own or rent your home and are living with someone, please have them fill out the information below:

_____ does live with me, and I help him/her financially with anything he/she may need. He/She does not work and has no income. I do ___ or do not ___ claim him/her on my taxes.

_____ _____ _____
Signature Relationship Date