FREEMAN
Health System

Financial Assistance instructions:

Freeman Health System is a non-for-profit health system offering Financial Assistance (FA) to our patients that qualify based on income in relation to the Federal Poverty Guidelines and available assets. FA considerations requested by customers must have a completed application submitted with supporting documentation to be considered for assistance up to 100% of patient responsibility.

Partially completed applications will be returned to the customer to provide complete application including supporting documentation. To expedite your application please review and submit all relative documents noted below.

☐ **Proof of Identity:** *Please provide at least one of the following documents:*
- ☐ Driver's license or state ID
- ☐ Social security card
- ☐ Alien resident card or a United States citizen identification card

☐ **Proof of Income:**
(This includes spouses)
Section Below)
- ☐ Current employers most recent check stub with year to date noted, for all employers during the calendar year.
- ☐ Pay cards (where employment or aid is paid to, as opposed to a bank/savings account.)
- ☐ Unemployment
- ☐ Child support
- ☐ Public assistance (Medicaid, TANF, Food Assistance, WIC, etc.)
- ☐ Social security/award letter
- ☐ Veterans benefits
- ☐ Workers compensation
- ☐ Strike benefits

☐ **Personal Taxes:**
(This includes Business taxes if self-employed)
- ☐ Business income taxes
- ☐ Personal income taxes
- ☐ Any schedules that may be attached - *Personal Property taxes not required

☐ **Other**
- ☐ Health savings or health reimbursement accounts

☐ **If you did not file taxes:**
- ☐ Proof of non-filing from the IRS by:

- Setting up appoint to go to IRS: 844.545.5640, IRS is located at US Bank Building on 4th and Main in Joplin has an IRS office to assist in proof of non-filing or copy of past tax year.
- Online: https://www.irs.gov/individuals/get-transcript
- Submitting 4506-T or 4506T-EZ forms to the IRS
- Call 800.908.9946 to request proof

☐ **If you have applied for Medicaid and have been Denied or Approved**
- ☐ Valid Medicaid denial letter
- ☐ Valid Medicaid acceptance letter

☐ **If you have not applied for Medicaid:**
- ☐ Complete the attached financial screening protocol entitled "Upfront Decision Tree"; If eligibility criteria is not found you may be eligible for FA, and application should be complemented. If indication of eligibility or potential eligibility for program, application must be completed prior to consideration of FA.

☐ **If this is for a future service or surgery:**
- ☐ A letter of medical necessity from the doctor requesting the services

Please note policy will be reviewed to assure Medically Necessary guidelines are met.

☐ **Completed Financial Assistance Application**
- ☐ Sign and date application. Please complete all sections of the application if not applicable please indicate N/A.

You may obtain additional applications by visiting the main registration desk at any Freeman hospital or physician clinic, calling Freeman Patient Accounts or online at freemanhealth.com/paymentoptions

We are available to assist you with any questions Monday–Friday, 8:00am–4:30pm at 417.347.8247 or 888.707.4500.

Mailing Address for Applications:
Freeman Health System
Patient Accounts
1102 W. 32nd Street
Joplin, MO 64804
Phone: 417.347.8247
Fax: 417.347.5818

Physical Address:
Freeman Business Center
Patient Accounts
3220 McClelland Blvd.
Joplin, MO 64804
Phone: 417.347.8247
Fax: 417.347.5818

Email: Completed Applications with <u>all</u> required attachments can be sent electronically to: freemanfinancialassistance@freemanhealth.com

FREEMAN Health System

Freeman Financial Assistance Application

ADMISSIONS/PATIENT ACCOUNTS USE ONLY

☐ Approved 100%	☐ Pended/Acct. rep.
☐ Approved sliding scale/patient owes: %	☐ UB status/Acct. rep.
☐ Denied due to:	☐ Med. assist/Acct. rep.

Account #: _____ Unit #: _____ Date submitted: _____

APPLICANT/PATIENT INFORMATION

Patient Name: _____ Patient Social Security #:_____

Patient Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Message phone: _____ Driver's license #: _____

Parent/ Guardian Name: _____ Parent/ Guardian Social Security #: _____

Parent/ Guardian Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____ Message phone: _____ Driver's license #: _____

HOUSEHOLD INFORMATION (mother, father and dependent children under the age of 18 only)

Name	Date of Birth	Age	Name	Date of Birth	Age
SELF			DEPENDENT		
SPOUSE			DEPENDENT		
DEPENDENT			DEPENDENT		
DEPENDENT			DEPENDENT		

HOUSEHOLD EMPLOYMENT/ ANNUAL INCOME INFORMATION

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				0
Social Security, annuity, veterans benefits				0
Alimony, child support, military family allotments				0
Income from business self-employment and dependents				0
Rent, interest, dividend, unemployment and other income				0

APPLICANT ACKNOWLEDGEMENT

I understand I (applicant/patient) will be expected to apply for Medicaid assistance in paying for this hospital service. I further understand the information I have given is subject to verification and review by Freeman. Should I receive or have any income not listed, I understand that my approval for financial assistance can be withdrawn and I will then be responsible for paying my account. I certify the information provided is true and correct, under penalty of perjury.

Applicant signature: _____ Date: _____

Employee signature: _____ Date received: _____

Approval pending: ☐ Proof of income ☐ Personal taxes ☐ Business taxes ☐ Copy of Driver's license/SS card

Date information is due: _____Approved by: _____ Date: _____

Freeman Health System
Financial Screening Protocol
"Upfront Decision Tree"

Pt. Account #_____

Circle the correct answer to each of the questions below.

PART I – Insurance Coverage

1. Do you have medical insurance coverage? ☐ **Yes or No** ☐
   If yes, then follow protocol for verifying eligibility/benefits protocol.
2. Were you treated for injuries that were caused by an accident? ☐ **Yes or No** ☐
   If yes, then follow protocol for 3rd party liability potential.
3. Do you have medical insurance that has expired in the past 60 days? ☐ **Yes or No** ☐
   If yes, then follow protocol for reviewing COBRA and/or Affordable Care potential.
4. Have you applied for health insurance through the Healthcare Marketplace? ☐ **Yes or No** ☐

   If yes, please indicate the outcome: _____

   If no, our office may contact you to discuss this option of healthcare coverage.

The Health Insurance Marketplace is a web site where individuals, families, and small businesses can learn about their health coverage options; compare health insurance plans based on costs, benefits, and other important features; choose a plan; and enroll for coverage through the Affordable Care Act.

Part II Medicaid Quick Screening Questions*:*

- Are you the parent of minor children and do they live in the home with you? ☐Yes or No☐
  If yes, do either biological parent in the household work? ☐Yes or No☐

  If yes, what is their gross income? _____ see income guidelines below:

  No. of persons in household/income guidelines:
  - 1 - $136.00/month
  - 2 - $234.00/month
  - 3 - $292.00/month
  - 4 - $342.00/month
  - 5 - $388.00/month
  - 6 - $431.00/month
  - 7 - $474.00/month

If income is over the income guidelines, patient will not qualify for Medicaid.
Decision Tree can be used as a denial for Medicaid. Proceed with Financial Assistance.

- Are you currently receiving Social Security income based on a disability? ☐ Yes or No ☐
- Have you applied for Social Security Disability benefits in the last 6 months? ☐ Yes or No ☐
- Are you currently unable to work due to a disability? ☐ Yes or No ☐
- Are you currently pregnant or have you delivered in the last 90 days? ☐ Yes or No ☐
- Are you considered legally blind? ☐ Yes or No ☐
- Are you age 65 or older? ☐ Yes or No ☐
- Does Patient or Guarantor meet the Federal Poverty Guidelines for income? ☐ Yes or No ☐

If any of the above questions are answered with a "YES", and/or are under income guidelines, direct the patient to the Eligibility Partner for Medicaid application.