APPLICATION FOR
FINANCIAL ASSISTANCE
and UNINSURED DISCOUNT POLICY

Dear Patient/Guarantor:

We at Doctors Memorial Hospital understand the difficulty in meeting financial obligations especially when there are unexpected illnesses. In an effort to assist you during this time, we want to offer financial help with your bill, if qualified, or a discount based on the hospital's Medicare Cost to Charge percentage. Doctors Memorial Hospital wants to help lower the financial responsibility of our uninsured patients to what is normally allowed by other insurers, regardless of whether or not they qualify for Financial Assistance. The discount is applied prior to your initial bill going out. In order to have all or a portion of your allowable charges written off under DMH's Financial Assistance policy, the items listed below need to be brought in by you as part of the qualifying process. We are now required to maintain proof of income and expenses in order to write off your bill as part of our Financial Assistance program.

1. Copy of Social Security Card
2. Copy of Driver's License or State Identification for ALL over 18 years of age.
3. Proof of Income; If not working, just bring a letter from the person(s) who is/are assisting you with paying your bills. If self employed, your last Income Tax Return will be sufficient proof of income.
4. All monthly bills (example: electric, phone, insurance, rent or house payment, car payment, garbage, cable, etc.) will also be required in some instances.

In addition to bringing these items in, there are 2 short forms to be completed that will finalize the qualifying process. We can help you complete them when you bring the other information in. These are also attached to this information sheet regarding our Financial Assistance program.

Doctors Memorial Hospital's Financial Representative is Diane Sanders. She works Monday thru Friday from 8am – 5pm, in the hospital Business Office. Her direct phone number is (850) 547-8030. If you are unable to come by during normal business hours, all of the information and copies of bills/income can be left with the Emergency Room Clerk, who will then forward on to the Business Office for processing.

If you should have any questions, please feel free to give me a call at (850) 547-8015 at your convenience.

Thank you,

Donna Boroughs

Donna Boroughs
Business Office Director

If necessary, paperwork can be faxed to the Business Office at 850-547-8024

Summary of Doctors Memorial Hospital's
Financial Assistance Policy

Doctors Memorial Hospital is committed to improving the health of individuals and communities located in our region. We seek to provide quality care to individuals, regardless of their ability to pay and have established a financial assistance program to help qualifying residents of our service area, with limited financial resources, in paying for their medical care.

ELIGIBILITY

A patient or guarantor (a person, other than the patient, who is responsible to pay the patient's bill) is eligible for financial assistance, help or aid based on where he or she lives, gross (*the amount before taxes and other amounts are taken from pay) household income and the number of people living in the household.

Residency: To be approved for 100% financial assistance, you must be a permanent resident of Doctors Memorial Hospital's primary service area, or a student who is not a permanent resident attending school in one of these areas. Immigrants must have a "Permanent Resident Card" (Form I-551), "Resident Alien Card" or a "United States Citizen Identification Card."

Primary service area zip codes:
32425, 32427, 32428, 32464, 32455, 32462, 32440

Applicants living outside Doctors Memorial Hospital's primary service area will be considered for discounted care based on gross household income and household size.

Gross household income: Doctors Memorial Hospital's patients or guarantors with gross household income up to 250% of the Federal Poverty Guidelines. See the page 2 for more information on gross household income and household size.

- Free and discounted care guidelines

Federal poverty level from the current year	Discount within primary service area**	Discount outside of primary service area**
100%	100%	50%
101% to 133%	75%	25%
134% to 138%	50%	15%
139% to 250%	25%	10%
251% to 400%	No discount	No discount

ASSISTANCE

Free care is given to hospital patients or guarantors who have a household income up to 100% of Federal Poverty Guidelines. A 75% discount will be given to patients or guarantors whose income is between 101% and 133%. A 50% discount will be given to patients or guarantors whose income is between 134% and 138%. A 25% discount will be given to patients or

guarantors whose income is between 139% and 250%. No discount will be given for income exceeding 250% of Federal Poverty Guidelines.

Limitations on fees and charges: Those eligible for assistance will be granted a discount on Doctors Memorial Hospital's bills for care that is medically necessary or an emergency, and the fees they must pay will not exceed the amount generally billed by Medicare.

How to obtain information and apply for assistance: To get a free copy of the full financial assistance policy and a financial assistance application, visit www.doctorsmemorial.org, or call our Patient Representative at (850) 547-8030 to request the information be mailed to you. You may also present to the Business Office at 2600 Hospital Drive, Bonifay, FL 32425 Monday through Friday 8:00 a.m. to 4:00 p.m..
If you need help filling out the financial assistance application, call (850) 547-8030 to make an appointment.

DOCTORS MEMORIAL HOSPITAL

Number in Household	100% discount if income is = or < than:	75% discount if income is = or < than:	50% discount if Income is = or < than:	25% discount if income is = or < than:
1	$11,770	$15,654	$16,242	$29,425
2	$15,930	$21,186	$21,983	$39,825
3	$20,090	$26,719	$27,724	$50,225
4	$24,250	$32,252	$33,465	$60,625
5	$28,410	$37,785	$39,205	$71,025
6	$32,570	$43,318	$44,946	$81,425
7	$36,730	$48,850	$50,687	$91,825
8	$40,890	$54,383	$56,428	$102,225

For each additional household member, add $4,160.

Definition of household: Family of one is a person who may be the only one living in a housing unit or who may be living in a housing unit in which one or more persons also live, but are not related to the applicant by marriage, birth or adoption. For example, people who live with others include a lodger, a foster child, a ward or an employee. A family of two or more persons includes people who are related by marriage, birth or adoption who live together; all such related persons are thought of as members of one family; an unmarried couple with a mutual child; and same-sex couples who are married. If a household includes more than one unrelated family, the poverty guidelines are applied separately to each family and not to the household as a whole. Sometimes, a copy of a divorce decree or court documents proving legal separation may be required. If married, but not living together, income documents will be required from both people.

Definition of income: Income is how much everyone who lives in the household makes, before taxes are taken out, from all sources (gross income).
Income data for part of a year may be figured based on what might have been received in an entire year to determine eligibility-for instance, by multiplying the amount of income received during the most recent three months by four.

DOCTORS MEMORIAL HOSPITAL
Tax ID#: 59-6031176
UNINSURED PATIENTS
QUALIFYING FOR ASSISTANCE

Doctors Memorial Hospital makes an effort to find assistance for patients who are uninsured and need treatment. Any emergency room visit that is deemed an emergency by the physician are treated regardless of ability to pay. This visit some times leads to an in-patient admission as well. The following are ways DMH attempts to help alleviate the burden for the patient by offering assistance:

HCRA PROGRAM (Health Care Responsibility Act)
If the patient is a Holmes County resident, the Business Office staff assists them with completing paperwork to qualify them for the HCRA program. This is based on income level and number of persons residing in the home. Since there are limited funds available each year, some may qualify, however the funds are depleted and the patient is treated as a regular charity write-off. If the funds are available, the hospital is reimbursed 80% of the current Medicaid rate for the facility. The remaining charges are written off to charity. Doctors Memorial Hospital is allotted approximately $37k each year to assist them in treating the uninsured Holmes county residents who are seen at the facility through the HCRA program.

MEDICAID
For the past several years, Doctors Memorial Hospital has partnered with the Department of Children and Family Services as an ACCESS community site. We have Business Office clerks that have access to the DCF website to utilize in helping patients or their family members apply for Medicaid.

DOCTORS MEMORIAL HOSPITAL
P. O. BOX 188
Bonifay, Florida 32425
(850) 547-8000
(850) 547-8024 (fax)

Patient Name: _____ *Address:* _____

_____

Account Numbers: _____

CHARITY CARE PROGRAM APPLICATION

Family Size (CIRCLE TOTAL LIVING IN YOUR HOUSEHOLD)	*Income Level* (CIRCLE INCOME RANGE)	*Patient/Guarantor Initials*
1	*$11,770 – $29,425*	
2	*$15,930 - $39,825*	
3	*$20,090 - $50,225*	
4	*$24,250 - $60,625*	
5	*$28,410 - $71,025*	
6	*$32,570 - $81,425*	
7	*$36,730 - $91,825*	
8	*$40,890 - $102,225*	

I, _____ , request consideration for the provision of discounted services for myself or my dependents. I attest that the above indicated family size and income level is an accurate representation of my current economic status. I authorize the hospital to verify my employment information as provided as a part of this application process if needed. I also understand that the State of Florida may require me to provide proof of income.

*Source of Income:*_____ *Gross:*_____*WK/BIWK/MTH*
(Employment, SSI, pension, child support, etc)

*EMPLOYERS NAME:*_____ *PHONE #:*_____

*PATIENT/GUARANTOR SIGNATURE:*_____

*WITNESS:*_____ *BUSINESS OFFICE MGR:*_____

FINANCIAL COUNSELING WORKSHEET

Patient Name: _____ ***Guarantor Name:*** same

Account#: _____ ***Primary Ins:*** none

Date: _____ ***# of Dependents:*** _____

MONTHLY EXPENSES	*AMOUNT*	*GUARANTOR ASSETS*	*VALUE*
Rent or Mortgage		Checking Accounts	
Natural or Bottle Gas		Savings Accounts	
Electricity		Real Estate	
Other Utilities		Other Cash Assets	
Telephone			
Cell Phone or Pager		***TOTAL VALUE:***	
Cable or Satellite			
Food		***MONTHLY INCOME***	
Automobile Payments		Earned Income	
Gasoline/Month		Retirement Income	
Loans		Government Income	
Credit Card Payments		Other Income	
Child Support			
Medical Bills			
		TOTAL MONTHLY INCOME:	
		Less Total Monthly Expenses	-
TOTAL MONTHLY EXPENSES:		***AVAILABLE AMOUNT:***	

Patient/Guarantor Signature: _____ ***Date:*** _____

**********TO BE COMPLETED BY DMH REPRESENTATIVE**********

Financial Counselor Signature: _____ ***Date:*** _____

APPROVED FOR ASSISTANCE: ***Y*** ***N***

CHARITY AMOUNT APPROVED: ***100%*** ***75%*** ***50%*** ***25%***

DENIED DUE TO: _____