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- I. **Purpose**: To establish a framework and guidelines for providing financial assistance to qualifying patients with an effective and consistent method for identifying eligible patients and for administration and allocation.
- II. **Scope**: This Financial Assistance Policy applies to Regional Hospital of Scranton (the “Facility”) and all of its affiliated entities that are not tax-exempt and, therefore, not subject to Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- III. **Policy**: The Facility is committed to treating all patients regardless of their ability to pay and to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for their medical care based on their individual financial situation. In accordance with the Emergency Medical Treatment and Labor Act (EMTALA), emergency and Medically Necessary Care will not be delayed or withheld based on a patient’s ability to pay. As a service to our community, we participate in state and/or county indigent programs where applicable and offer financial assistance to our patients care received at our Facilities subject to meeting eligibility criteria established herein and in accordance with the Facility’s specific policy and state requirements. No patient will be denied financial assistance due to his or her race, religion, national origin or any other basis prohibited by law.

This Policy is intended to be the minimum standard requirement for the Facility.

IV. **Definitions**:

- A. **Assets or Liquid Assets** – Assets, outside of a patient’s primary residence, that are capable of being converted to cash within one year. These include checking accounts, savings accounts (including flexible spending and health savings accounts), trust funds, certificates of deposit, bonds, marketable securities and other investments (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)). Additionally, Assets include the liquidated value of luxury items, equity in recreational vehicles, boats, a second home, etc.
- B. **Asset Test** – A substantive assessment of a patient’s ability to pay based on eligible liquid or cash Assets in the categories included in the FAP Application.
- C. **Catastrophic Claim** - A claim with a balance of at least \$50,000.00 after applying the Uninsured Discount, and the patient has indicated an inability to pay the balance.
- D. **Charity Care Discount** – A full or partial discount off gross charges for medical services available for eligible patients or patient guarantors with annualized family incomes up to specified percentage of the Federal Poverty Level.

- E. Federal Poverty Level – The Federal Poverty Level (“FPL”) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of United States Code, Title 42, Section 9902(2). Current FPL Guidelines can be found at <http://aspe.hhs.gov/poverty-guidelines>. We will update the FPL Guidelines for its Financial Assistance Program on an annual basis.
- F. Financial Assistance – A reduction in the amount that the patient owes for medical services based on the patient's financial need determined by the provisions of this Policy. This reduction is generally determined as a percentage of gross or net charges.
- G. Financial Assistance Program or “FAP” – As detailed herein, a program developed to identify and measure a patient's eligibility for either free or discounted Financial Assistance based on financial need and to outline the practice for allocating Financial Assistance in a consistent and efficient manner. Discounts offered under the Financial Assistance Program include the Charity Care Discount and the Uninsured Discount. Discounts above and beyond the protocol outlined in this Policy are not part of the Financial Assistance Program and are governed by the CHSPSC, LLC policies titled “Special Insurance and Patient Settlements” and “Financial Counseling.”
- H. Financial Assistance Program or “FAP” Application – The application a patient must complete in order to identify whether the patient is eligible for the Charity Care Discount available under the Facility Financial Assistance Program if the patient does not qualify for the Charity Care Discount under presumptive Charity Care.
- I. Gross Charges – The full, undiscounted price of medical services consistently and uniformly charged to patients before applying any contractual allowances, discounts or deductions.
- J. Insured – Patients with any type of insurance coverage and/or third-party payor program which reimburses for, compensates or discounts medical expenses. For purposes of this Policy, patients are considered to be insured even if their benefits are out-of-network.
- K. Medically Indigent - A patient whose Facility bills (after payment by third party payors) exceed a specified percentage of the patient's annual gross income, determined in accordance with the Facility's Charity Care Discount eligibility criteria.
- L. Medically Necessary Care – As defined by Medicare, services or items reasonable and necessary for the diagnosis or treatment of illness or injury.
- M. Policy – This Financial Assistance Policy.
- N. Uninsured – Patients for whom there is not a third party responsible for all or any portion of their medical expenses.
- O. Uninsured Discount – The flat-rate discount applied to eligible gross charges for Uninsured patients.

V. **Financial Assistance Policy and Procedures**

- A. Financial Assistance: Charity Care Discount
 - i. **Eligible Services.** Non-elective services eligible including services for Emergency Medical Conditions, as defined by Section 1867 of the Social Security Act (42 U.S.C. 1395dd), provided in an emergency room setting, are generally eligible for a Charity Care Discount. Services that are elective, non-medically necessary and/or cosmetic services may not be generally eligible for a Charity Care Discount at the Facility; however, the Facility CFO or Shared Services Center (“SSC”) may approve application of the Charity Care Discount for such services on a case-by-case basis.

- ii. **Applying for a Charity Care Discount.** A patient may apply for a Charity Care Discount at the time of service or any time after care has been provided during their billing cycle. Patients may obtain FAP Applications, as well as assistance with completing the application, by calling or visiting customer service at the following address:

Regional Hospital of Scranton

746 Jefferson Avenue

Scranton, PA 18510

570-340-4801

www.commonwealthhealth.net/financial-assistance-program

- iii. **Eligibility Screening.** All Uninsured patients screened for potential Medicaid eligibility as well as coverage by other sources, including other governmental programs and will be evaluated for eligibility to receive a Charity Care Discount under the Facility's Financial Assistance Program if it is determined that the patient does not appear to qualify for coverage under any program.

iv. **Patient Eligibility.**

1. At any time during the patient's billing cycle, a patient may complete an FAP Application which contains criteria to evaluate a patient's adjusted individual or family gross income under current Federal Poverty Level (FPL) Guidelines established by the Department of Health and Human Services, attached as **Appendix A**, which will be updated annually by the Facility. For a patient with an adjusted gross income less than or equal to the specified percentages of the current FPL Guidelines identified in **Appendix B**, the patient may be eligible for a Charity Care Discount off the entire bill or on a sliding scale basis, if the patient otherwise meets the eligibility criteria identified below. Additionally, a patient meeting the Facility's definition of Medical Indigency may also be eligible for a Charity Care Discount, if the patient otherwise meets the applicable eligibility criteria identified below. More information on the Facility's Charity Care Discount percentages is found in **Appendix B**.
2. Charity Care Eligibility Criteria. Eligibility for a Charity Care Discount will be determined through the criteria listed below and may include accounts for which other payment or funding sources exist.
 - a. All patients that wish to apply for a Charity Care Discount or are identified as a possible candidate for a Charity Care Discount will receive a FAP Application.
 - b. A patient that wishes to apply for a Charity Care Discount must complete the FAP Application and provide adequate documentation, as outlined below, supporting their financial income and expenses to be considered for charity care.
 - c. A patient may be considered for a Charity Care Discount either at the time of service or after service is provided.
 - d. A patient is deemed eligible for a Charity Care Discount after Facility evaluation of the completed FAP Application if the patient,
 - (1) Is Uninsured;
 - (2) Received or is scheduled to receive Medically Necessary Care;
 - (3) Financial criteria falls within a specified percentage of the FPL Guidelines established by the Department of Health and Human Services for the patient's applicable family size, as described by each Facility in **Appendix B**; and
 - (4) Financial status is validated using documentation provided by the patient to verify patient's assets, pursuant to the Facility's patient Asset Test.

- e. Even if a patient FAP Application evaluation determines that the patient's FPL score exceeds the specified percentage identified in **Appendix B**, a patient may also qualify for a Charity Care Discount after Facility evaluation of the FAP Application if,
 - (1) The patient is Medically Indigent;
 - (2) The patient's account balance from the Facility for Medically Necessary Care exceeds a specified percentage of the patient's annual gross income (after payment by third party payors and excluding patient's cost-sharing amounts), as described by the Facility in **Appendix B**; and
 - (3) The patient's financial status is validated using documentation provided by the patient to verify patient's assets, pursuant to the Facility's patient Asset Test.
 - f. **Patients eligible for Medicare must complete and submit a FAP Application and an Asset Test in order to qualify for a Charity Care Discount for benefits not covered by Medicare.**
 - g. The FAP Application must be provided to the patient or responsible party, completed and returned prior to applying any Charity Care Discount account adjustment.
 - h. A patient that is deemed not eligible for Charity Care may still be considered for other types of assistance under the Financial Assistance Program or may qualify for discounts available at the Facility that are not part of the Financial Assistance Program.
2. Criteria for Evaluating FAP Applications.
- a. The FAP Application will request for the following financial information related to the patient:
 - (1) A copy of the last four pay checks stubs;
 - (2) Prior year Federal 1040 tax return;
 - (3) Unemployment benefits (check stubs);
 - (4) Social Security benefits (copy of check or letter from Social Security);
 - (5) Department of Social Services grants and/or amount of food stamps;
 - (6) List of personal expenses, including but not limited to rent, house payment, utilities, car payment, insurance, food, etc.; and/or
 - (7) Other documents needed to verify Assets to determine eligibility.
 - b. The Facility's FAP Application is found in **Appendix D**.
 - c. **Tax Filings.** Where the patient/guarantor indicates they do not file federal tax returns, the Facility will request that the patient/guarantor complete IRS Form 4506-T (Request for Transcript of Tax Return). The patient/guarantor should complete lines 1-5 after the Facility has completed lines 6-9. The Facility will complete line 6 by entering '1040', will check boxes 6(a) and box 7. In box 9, the Facility will enter prior year and prior 3 years. A copy of the IRS Form 4506-T is attached hereto as **Appendix C**.
 - d. **Asset Test.** Applying the Asset Test, a patient with Assets that exceed 400% of the FPL or have \$100,000 or more in eligible or liquid Assets (i.e. cash, bonds, certificates of deposit), for the guarantor or patient may not be eligible for the Charity Care Discount. The Chief Financial Officer and the Patient Access Director will determine the amount due if the patient's liquid assets exceed \$100,000.
 - e. Patients will initially be given thirty (30) days to complete and return the FAP Application and all necessary documentation to the Facility or the Shared Service Center (SSC). The FAP Application will be sent to the Facility financial counselor or SSC designated director for final determination.
3. Information Not Available.

- a. A patient who is unable to provide the above-mentioned documentation to support a charity care eligibility determination must contact the Facility or the SSC to discuss alternative information that the patient may provide to demonstrate eligibility. Notarized letters from family members, neighbors, etc. stating or certifying the patient has no income or other financial resources may not be considered adequate documentation.
 - b. A patient's failure to provide sufficient information to meet the Facility eligibility requirements, may result in a denial of the FAP Application.
4. Incomplete Information.
- a. A patient should be notified in-person, by mail, or by telephone if required information received is incomplete. The patient may submit the missing information within thirty (30) days from the date the notice was mailed, the in-person conversation took place, or the telephone conversation occurred.
 - b. Applications that remain incomplete after thirty (30) days from the date the notice was mailed may result in denial of application.
 - c. The application may be reopened and reconsidered once the required information is received.
 - d. Accounts for which complete documentation is not received will be returned to the normal collections workflow.
5. Denial.
- a. A patient or guarantor who applied for a Charity Care Discount but was denied may be informed in writing that their request for a Charity Care Discount was denied.
 - b. The patient or guarantor may appeal the determination of eligibility for financial assistance by providing additional information or verification that you believe will impact this decision within thirty (30) days receipt of notification of denial. Following this evaluation, written notification of the determination from that reconsideration will be provided to the patient/ guarantor.
 - c. Even if a patient's FAP Application is denied, the patient may still be eligible for other assistance offered at the Facility under the Financial Assistance Program.
6. Length of Eligibility.
- a. The patient's account status will never be permanently designated as eligible for a Charity Care Discount; rather the patient's status will be reviewed every three (3) months. This means that a patient's eligibility determination remains effective for three (3) months, during which other accounts belonging to the same patient may be added to the previous approval, if requested by the patient. The Facility may require a new FAP Application or presumptive qualifications evaluation once the three (3) month period of eligibility expires, measured from the date of approval. The Facility may also require a new FAP Application or presumptive qualifications evaluation within the three (3) month period, if a patient's financial situation appears to or is suspected to have changed.
 - b. If an account is written off to bad debt per the Facility's Bad Debt Policy, and at least two-hundred and forty (240) days have elapsed since the Facility mailed the first billing statement for the care invoiced, the care involved may no longer be eligible for financial assistance under this Program.
 - c. A patient's Charity Care Discount may be revoked, rescinded or amended if,
 - (1) A patient received the discount due to circumstances which undermines the Financial Assistance Program;
 - (2) Other payment sources are identified after receiving the Charity Care Discount; or

(3) A change in healthcare insurance coverage is identified after receiving the Charity Care Discount.

7. Out-of-State Medicaid Recipient.

- a. Patients covered by out-of-state Medicaid where the Facility is not an authorized provider and where the out-of-state Medicaid enrollment or reimbursement makes it not cost effective for the Facility to become a provider will be eligible for charity care upon verification of Medicaid coverage for the service dates since they will be considered uninsured. No other documents will be required in order to approve the FAP Application. The patient will not be required to make a formal FAP Application. The Facility may submit the application and verification of Medicaid coverage as proof of qualification.

v. Collection Efforts.

1. All collection efforts should be suspended if the patient has submitted a complete FAP Application and all accompanying documentation. Collection efforts should be suspended until a final eligibility determination is made. However, if the FAP Application and / or accompanying documentation is incomplete, collection efforts and statement processing will continue until all the required documentation is received.
2. If a patient is awarded a 100% balance adjustment under the Policy, collections efforts will cease. However, if the patient is awarded a sliding scale adjustment that is less than 100%, collections efforts and statement processing may resume for the remaining balance not adjusted under the Policy.
3. If a patient is awarded a Charity Care Discount, any deposits or payments received from the patient for that care must be refunded if the payments exceed any balance remaining after application of the all Financial Assistance discounts.

vi. Publicity of Charity Care.

1. At the time of service, all patients should be notified of the possibility of a Charity Care Discount under the Facility Financial Assistance Program.
2. An opportunity to complete a FAP Application should be given to all patients that wish to apply for a Charity Care Discount or have been recommended by practice staff, a physician or a financial counselor for a Charity Care Discount.
3. A patient may request a FAP Application in-person, by phone, by mail, or by accessing the electronic version via the Facility's website, if available. Copies of the policy, application forms, and instructions should be made available free of charge.
4. Patients should be provided a written notice with their bill that contains information regarding the Charity Care Discount including information about applying for charity care and contact information for the Business Office where the patient may obtain further information about this and other Financial Assistance available under this policy.
5. Information about the Charity Care Discount should be posted in languages representative of the Facility's patient demographics and in conspicuous places, including but not limited to posting notices in the emergency rooms, urgent care centers, admitting and registration departments, business offices and patient financial services offices that are located at the Facility. Additional notice may be required under state law.
6. Any evaluation of financial arrangements will occur only after an appropriate medical screening examination has occurred and necessary stabilizing services have been provided in accordance with EMTALA and all applicable state and federal regulations.

B. Financial Assistance: Uninsured Discount

- i. Uninsured patients who are not eligible for or who have not been identified as eligible for a Charity Care Discount may receive an Uninsured Discount. More information on the Facility's Uninsured Discount percentages is found in **Appendix E**.
- ii. **Eligibility.** The Uninsured Discount only applies to Uninsured patients.
 1. Patients with health insurance may still be considered "Uninsured" for purposes of eligibility for the Uninsured Discount under the following circumstances:
 - a. The patient's insurance does not cover the patient visit through no fault of the patient; or
 - b. The patient's applicable benefits have been exhausted.
 2. Insured Patients may not receive an Uninsured Discount if the above conditions are due to the patient's failure to follow procedures under his or her insurance policy.
- iii. The Uninsured Discount will be applied at the time when the Facility is able to identify and classify a patient as Self-Pay/Uninsured and will be reflected on a patient's final bill.
- iv. If, after the Uninsured Discount is applied to a patient account, the Facility determines that the patient has adequate insurance within timely filing limitations, the patient's insurance will be billed for the account, and the Uninsured Discount will be reversed if the patient's benefits cover the billed services.

C. Financial Assistance: Catastrophic Claim Discount

- i. Uninsured patients with certain high balances for medical treatment may receive a Catastrophic Claim Discount in addition to an Uninsured Discount. More information on the Facility's Uninsured Discount percentages is found in **Appendix F**.
- ii. **Eligibility.**
 1. The Catastrophic Claim Discount will apply to claims with a patient balance of at least \$50,000.00 after applying the Uninsured Discount to the claim.
 2. The Catastrophic Claim Discount only applies to Uninsured patients. Patients with health insurance may still be considered "Uninsured" for purposes of eligibility for the Uninsured Discount under the following circumstances:
 - a. The patient's insurance does not cover the patient visit through no fault of the patient; or
 - b. The patient's applicable benefits have been exhausted.

Appendix A

The 2021 poverty guidelines are in effect as of January 13, 2021, as published by the Department of Health and Human Services on its website: <https://aspe.hhs.gov/poverty-guidelines>.

2021 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in Family / Household	Poverty Guideline
For families/households with more than 8 persons, add \$4,540 for each additional person.	
1	\$12,880
2	\$17,420
3	\$21,960
4	\$26,500
5	\$31,040
6	\$35,580
7	\$40,120
8	\$44,660

Appendix B**Charity Care Discount**

Patients at Regional Hospital of Scranton may be eligible for our Charity Care Discount when they receive or are scheduled to receive Medically Necessary services at the Facility, as defined in the Policy and below.

Patients eligible for a Charity Care Discount under the Policy who have a gross family income at or below 100% of the FPL may receive a deduction for the entire Gross Charges, if their financial status is validated using documentation provided by the patient in the application process.

Patients eligible for a Charity Care Discount under the Policy who have a gross family income that exceeds 100% of the FPL may still receive a deduction from Gross Charges based on their proportion of family income to Federal Poverty Level Guidelines (FPL) or to the Facility bill, if validated using documentation provided by the patient in the application process, as follows:

- Patients with family income of 101%-200% of the FPL will receive a balance adjustment of 90% of Gross Charges;
- Patients with family income of 201%-300% will receive a balance adjustment of 85% of Gross Charges;
- Patients with family income of 301%-400% will receive a balance adjustment of 80% of Gross Charges; and
- Patients whose balance due from the Facility exceeds 25% of the patient's annual gross income (after payment by third party payors and excluding patient's applicable cost-sharing amounts under the patient's policy) will receive a balance adjustment of 80% of Gross Charges.

A patient with Assets that exceed 400% of the FPL or have \$100,000 or more in eligible or liquid Assets (i.e. cash, bonds, certificates of deposit), for the guarantor or patient may not be eligible for the Charity Care Discount.

Appendix C

Form 4506-T (March 2017) Department of the Treasury Internal Revenue Service	Request for Transcript of Tax Return • Do not sign this form unless all applicable lines have been completed. • Request may be rejected if the form is incomplete or illegible. • For more information about Form 4506-T, visit www.irs.gov/form4506t .	OMB No. 1545-0047
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Tip: Use Form 4506-T to order a transcript or other return information free of charge. See the product list below. You can quickly request transcripts by using our automated self-help service tools. Please visit us at irs.gov and click on "Get a Tax Transcript..." under "Tools" or call 1-800-829-6646. If you need a copy of your return, use **Form 4506, Request for Copy of Tax Return**. There is a fee to get a copy of your return.

1a Name shown on tax return. If a joint return, enter the name shown first.	1b First social security number on tax return, individual taxpayer identification number, or employer identification number (see instructions)
2a If a joint return, enter spouse's name shown on tax return.	2b Second social security number or individual taxpayer identification number if joint tax return

3 Current name, address (including apt., room, or suite no.), city, state, and ZIP code (see instructions)

4 Previous address shown on the last return filed if different from line 3 (see instructions)

5 Customer file number (if applicable) (see instructions)

Note: Effective July 2016, the IRS will mail tax transcript requests only to your address of record. See **What's New** under **Future Developments** on Page 2 for additional information.

6 Transcript requested. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request. • _____

a **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years. Most requests will be processed within 10 business days. ☐

b **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns. Most requests will be processed within 10 business days. ☐

c **Record of Account**, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years. Most requests will be processed within 10 business days. ☐

7 **Verification of Nonfiling**, which is proof from the IRS that you **did not** file a return for the year. Current year requests are only available after June 15th. There are no availability restrictions on prior year requests. Most requests will be processed within 10 business days. ☐

8 **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript.** The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213. Most requests will be processed within 10 business days. ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

9 Year or period requested. Enter the ending date of the year or period, using the mm/dd/yyyy format. If you are requesting more than four years or periods, you must attach another Form 4506-T. For requests relating to quarterly tax returns, such as Form 941, you must enter each quarter or tax period separately. _____ / _____ / _____

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-T on behalf of the taxpayer. **Note:** This form must be received by IRS within 180 days of the signature date.

☐ Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-T. See instructions.

Phone number of taxpayer on line 1a or 2a _____

Sign Here

Signature (see instructions) Date _____

Title (if line 1a above is a corporate officer, partner, etc., see instructions)

Spouse's signature Date _____

Appendix D**Financial Assistance Program Application**

Our hospital is committed to care for all patients regardless of their ability to pay. Patients who are unable to pay for services may be eligible for Financial Assistance. Please complete and return the following form with requested documents to the Facility Registration Department or Financial Counselor to be evaluated for Financial Assistance.

Patient Account(s) #: _____

Date of Application: _____

PATIENT INFORMATION

Name: _____

Address: _____

City: _____

State/Zip: _____

SSN: _____

Employer: _____

Address: _____

City: _____

State/Zip: _____

Work Phone: _____

Length of Employment: _____

Supervisor: _____

PARENT/GUARANTOR/SPOUSE

Name: _____

Address: _____

City: _____

State/Zip: _____

SSN: _____

Employer: _____

Address: _____

City: _____

State/Zip: _____

Work Phone: _____

Length of Employment: _____

Supervisor: _____

RESOURCES

Checking: Yes _____ No _____ Amount: \$ _____

Savings (including flexible spending and health savings accounts):

Yes _____ No _____ Amount: \$ _____

Bonds: \$ _____

Cash on Hand: \$ _____

Certificate of Deposit(s): \$ _____

IRA Account(s): \$ _____

Roth Account(s): \$ _____

Stock/Other Financial Investment Account(s) (excluding assets in retirement savings plans that may not be withdrawn without penalty (e.g., a 401(k)) : \$ _____

Trust Fund Account(s): \$ _____

Vehicle 1: Yr: _____

Make: _____

Model: _____

Vehicle 2: Yr: _____

Make: _____

Model: _____

Vehicle 3: Yr: _____

Make: _____

Model: _____

Vehicle 4: Yr: _____

Make: _____

Model: _____

Vehicle 5: Yr: _____

Make: _____

Model: _____

(This includes recreational vehicles such as: boats, campers, etc.)

INCOME

Patient/Guarantor Wages
(monthly): \$ _____

Spouse/Second Parent Wages
(monthly): \$ _____

Other Income

Child Support: \$ _____

VA Benefits: \$ _____

Workers Comp: \$ _____

SSI: \$ _____

Other Income

Child Support: \$ _____

VA Benefits: \$ _____

Workers Comp: \$ _____

SSI: \$ _____

LIVING ARRANGEMENTS

Primary Residence:

Rent: \$ _____ Own: \$ _____ Other(explain): \$ _____

Landlord/Mortgage Holder: _____

Phone Number: _____

Monthly Payment: \$ _____

Second Home/Other Property: Rent: _____ Own: _____ (check one)

Value: \$ _____ Loan Amount: \$ _____ Payment: \$ _____

House Rent/Mortgage Payment: \$ _____

Other Property Payment: \$ _____

Utilities: \$ _____

Gas: \$ _____

Auto: \$ _____

Loans: \$ _____

Medical Bills: \$ _____

Food: \$ _____

Child Support: \$ _____

Other: \$ _____

REQUESTED AVAILABLE DOCUMENTS

Proof of Income:

- ___ Last 4 paystubs
- ___ Letter from employer
- ___ Social Security benefits (if applicable)
- ___ Last 3 months bank statements
- ___ Previous years Federal Tax Return

Proof of Expenses:

- ___ Copy of mortgage payment OR
- ___ Copy of rental agreement
- ___ Other documents requested
- ___ Copies of monthly bills

The information provided in this application is subject to verification by the hospital and has been provided to determine my ability to pay my debt. I understand that any false information provided by me will result in the denial of any financial assistance by the hospital.

Signature of Applicant: _____

Hospital Representative completing the application: _____

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REGIONAL HOSPITAL OF SCRANTON FINANCIAL ASSISTANCE POLICY

Appendix E

Uninsured Discount

Regional Hospital of Scranton offers a discount of 58% from gross charges for inpatient services and 65% from gross charges for outpatient services for all Uninsured patients eligible for the Uninsured Discount under this Policy.

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REGIONAL HOSPITAL OF SCRANTON FINANCIAL ASSISTANCE POLICY

Appendix F

Catastrophic Claim Discount

Regional Hospital of Scranton offers a discount for patient accounts that meet the eligibility requirements for the Catastrophic Care Discount under this Policy. For eligible Uninsured patient accounts with balances of at least \$50,000.00 after applying Regional Hospital of Scranton's Uninsured Discount, the patient balance for a Catastrophic Claim will be reduced to 300% of Medicare reimbursement (excluding outlier calculated amount, if applicable).