Financial Assistance Program
Documentation Checklist

Please see the Financial Assistance Policy for eligibility requirements. Your application must include copies of any of the following documents that apply to you. Please attach copies, not originals, as we can't return any documents sent with the application. If any of the documents are missing, it will delay the processing of your application.

Attach a copy of Patient and/or Guarantor's Driver license; State Identification Card, Visa or other proof of Identity and Residency

If Your Household Has Income:

•Wages, salaries, tips
•Pension or retirement income
•Unemployment compensation
•Alimony and/or child support
•Business income
•Dividends and interest
•Legal judgments
•Workers' compensation income
•Social security income
•Rent and royalties

Attach proof of your household income, which may include:

>Social Security benefit payments and/or pension/retirement distributions

>Award letters for Food Stamps (SNAP) or TANF or Township

>Unemployment or workers' compensation award letters

>Pay stubs for the last 30 days (pay stubs and/or 1099 forms)

>Most recent IRS Form 1040 with schedules or equivalent of Form 1040 for residences of other countries

>If you are self-employed, you must include a full tax return with Schedule C and/or profit and loss statement

>Dividends and Interest shown on bank statements, mutual fund statements, money market accounts, COD's, bonds, stocks, etc.

> Other income, such as trust funds, charitable foundations, etc. (statement from this month or last month)

>Liquid Assets – Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, real estate (other than primary residence) or other property immediately convertible to cash.

If You Have No Income:

If you have no income, send us a letter of support. The person who provides your support must sign the letter and have letter notarized.

Letter of Denial of Medical Assistance

You need to apply for Medical Assistance and send a copy of your Letter of Denial before we can approve your application.

Your Completed and Signed Financial Assistance Application Form

Please complete all the parts of the form that apply to you. Note that a separate application must be completed for each individual patient who is requesting financial assistance.

If you do <u>not</u> qualify for Financial Assistance <u>based on Income</u>, please talk with a financial counselor about Catastrophic Care Assistance.

Financial Assistance Program

To help us determine if you are qualified to receive financial assistance, complete and return the application to the one of the addresses below. Please attached all requested documents.

If you have any questions or need help completing the application please contact Financial Services

Southlake Campus
Financial Services
Methodist Hospital
8701 Broadway Ave
Merrillville, IN 46410
219-738-5508

Northlake Campus
Financial Services
Methodist Hospital
600 Grant Street
Gary, IN 46402
219-886-4584

Account Number(s):____

Name of Patient:	
Patient's Date of Birth (mm/dd/yyyy):	
Patient's Address:	
Patient's City, State, and Zip Code:	
Patient's Cell Phone:	Patient's Daytime Phone:
Patient's Employer's Name:	Patient's Employer's Phone Number:
Patient's Social Security Number:____________________. Note: Social Security Number is required for some public health programs, including Medicaid. Providing your Social Security Number will help us know if you can qualify for any public health programs.	

If Guarantor is the Patient – skip this section	
Name of Guarantor	
Guarantor's relationship to Patient:	
Guarantor's Address:	
Guarantor's City, State and Zip Code:	
Guarantor's Cell Phone:	Guarantor's Daytime Phone:
Guarantor Employer's Name:	Guarantor's Employer's Number:

Guarantor Spouse – skip if no Spouse
Name of Guarantor's Spouse:
Guarantor's Spouse's Address:
Guarantor's Spouse's City, State and Zip:
Guarantor's Spouse's phone number:

Does Patient have health insurance? Yes No	If have insurance, what is name of insurer?
Did you apply for Medical Assistance in the past 6 months? Yes No	
If yes, please enclose a copy of the Letter of Denial.	
Do you have a lawsuit, settlement, personal injury or liability claim pending for this date(s) of service/treatment of care? Yes No If Yes, provide details	

Household Information: List ALL members of your household, including dependents, who were on your most recent IRS Form 1040. If you are now divorced or separated, please provide proof. If pregnant, count as two members.

Name	Relation to Patient	Age
Total number of household members (including the patient):		

Monthly Household Income: Give monthly income for yourself and other household members. Also attach copies of your proof of income and asset documents (see documentation checklist).

Monthly Gross Income	Self	Spouse and/or Other Household Members
Wages/self-employment	$	$
Social Security	$	$
Pension or retirement income	$	$
Dividends and interest	$	$
Rents and royalties	$	$
Unemployment	$	$
Workers' compensation	$	$
Alimony and child support	$	$
Legal judgments	$	$
Business Income	$	$
Other Income	$	$
Liquid Assets (see checklist) -- if **less than** $10,000, enter $0. If **greater than** $10,000, list dollar amount that exceeds $10,000	$	$
Total Monthly Family Income used to determine eligibility for assistance	$	$

Additional Comments:

Notice: This application is intended to serve as a statement of policy and not as a contract or agreement with any patient or guarantor. This application does not entitle any person to financial assistance. This application does not create and is not intended to create any third party beneficiaries nor is it intended to create any legal rights with regard to any person or entity. The Information provided by patient/guarantor will be used only to determine financial responsibility for charges from Methodist (medical care, including hospital and applicable provider services) and will be kept confidential. The information provided to prove income and assets will not be returned. The submitted information concerning annual household income and household size is subject to verification by Methodist including, as necessary, obtaining financial information from employers, banks, and other entities listed by me in this application. **Only emergency and medically necessary healthcare services are eligible for free or discounted service.**

Certification: My signature authorizes Methodist to verify all information provided on this form, including authorization to check credit history, employment status, and other third party information sources to determine eligibility, for federal, state, and private medical programs. I certify that the above information is true and accurate to the best of my knowledge. I understand that if any information I have given is determined to be false, it may result in reversing the financial assistance approval and I will be liable for the full amount of all charges. I understand a determination for financial assistance is made solely at the discretion of Methodist.

Guarantor's Signature: ____________________________ Date:____________

Guarantor's Spouse's Signature: _______________________________ Date:____________

Letter of support

Patient medical record number/account number
Supporter's name
Relationship to patient/applicant
Supporter's address

To Methodist Hospitals,:

This letter is to advise that (patient's name) receives little to no income and I am assisting with his/her living expenses. He/She has little to no obligation to me.

By signing this statement, I agree that the information given is true to the best of my knowledge.

Signature of supporter ____ Date _______________

Notorized by the below:

Financial Assistance Policy
Appendix 2
(Effective March 1, 2022)

Income & Asset Thresholds: The following figures are the 2022 Health and Human Services poverty guidelines which were published in the Federal Register on January 21, 2022.

Number of Person(s) in Family/Houseold	100%	200%	250%	300%	400%	Asset Threshold (100% of pverty x 6)
1	$13,590.00	$27,180.00	$33,975.00	$40,770.00	$54,360.00	$81,540.00
2	$18,310.00	$36,620.00	$45,775.00	$54,930.00	$73,240.00	$109,860.00
3	$23,030.00	$46,060.00	$57,575.00	$69,090.00	$92,120.00	$138,180.00
4	$27,750.00	$55,500.00	$69,375.00	$83,250.00	$111,000.00	$166,500.00
5	$32,470.00	$64,940.00	$81,175.00	$97,410.00	$129,880.00	$194,820.00
6	$37,190.00	$74,380.00	$92,975.00	$111,570.00	$148,760.00	$223,140.00
7	$41,910.00	$83,820.00	$104,775.00	$125,730.00	$167,640.00	$251,460.00
8	$46,630.00	$93,260.00	$116,575.00	$139,890.00	$186,520.00	$279,780.00
For families/households of more than 8 people, add the appropriate amount for each additional person	$4,720.00	$9,440.00	$11,800.00	$14,160.00	$18,880.00	$28,320.00

Financial Assistance Policy
Appendix 3
Covered Providers and Departments

1) The Methodist Hospitals, Inc. (Hospital): All locations
2) Physician and physician extenders bill under Methodist's tax identification number, which are as follows: Methodist Physician Group; Indiana Surgical Associates at The Methodist Hospitals, Inc. Northwest Indiana Gastroenterology Center at Methodist

Note: Services must be covered by Financial Assistance Policy and provided by the above Covered Providers and Departments to qualify for financial assistance.

Providers <u>NOT</u> Covered by Financial Assistance Policy

1) Emergency Department Physicians/Physician Extenders
2) Radiologists/ Physician Extenders
3) Pathologists/Physician Extenders
4) Anesthesiologists/Physician Extenders
5) Hospitalists/Physician Extenders
6) All other physician and physician extenders <u>not</u> billed under Methodist's tax identification number

Financial Assistance Policy
Appendix 4
Amounts Generally Billed (AGB) Percentage

Methodist utilizes the "Look-Back" Method. Prospectively, Methodist may change the method of calculation and/or the AGB Billed Percentage at any time upon update to this policy.
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AGB Percentage for March 1, 2015 27.7% (72.3% Discount from charges. Based on Medicare claims discharged in 2014)

ABG Percentage for March 1, 2016 25.1%. (74.9% Discount from charges. Based on Medicare claims discharged in 2015)

ABG Percentage for March 1, 2017 23.3%. (76.7% Discount from charges. Based on Medicare claims discharged in 2016)

ABG Percentage for March 1, 2018 22%. (78% Discount from charges. Based on Medicare claims discharged in 2017)

ABG Percentage for March 1, 2019 21.2%. (78.8% Discount from charges. Based on Medicare claims discharged in 2018)

ABG Percentage for March 1, 2020 20.80%. (79.2% Discount from charges. Based on Medicare claims discharged in 2019 with zero balance as of Feb 2020)

ABG Percentage for March 1, 2021 20.80%. (79.2% Discount from charges. Based on Medicare paid claims discharged in 2020, as of Feb 10, 2021)

ABG Percentage for March 1, 2022 20.04%. (79.96% Discount from charges. Based on Medicare paid claims discharged in 2021, as of Feb 10, 2022)

Financial Assistance Policy
Appendix 5
Public Access to Policy

Information on the Methodist Financial Assistance Policy, and the Methodist Self-pay Billing and Collection Policy will be made available to patients and the community served by Methodist through a variety of sources.

1. Patients and guarantors may request free copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary via mail at:

   The Methodist Hospitals, Inc.
   Attn: Financial Services
   600 Grant Street
   Gary, Indiana 46402

2. Patients and guarantors may request free copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary via phone at (219) 886-4584 or (219) 738-5508.

3. Patients and guarantors may download copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary via **www.methodisthospitals.org/billing_info/obtaining-financial-assistance/**.

4. Patients and guarantors may request free copies of the Financial Assistance Policy, the Self-Pay Billing and Collection Policy, the Financial Assistance Application, and/or the Plain Language Summary in person at the following locations:

   Methodist Hospitals
   600 Grant Street
   Gary, Indiana 46402

   Methodist Hospitals
   8701 Broadway
   Merrillville, Indiana 46410

Financial Assistance Policy
Appendix 6
Plain Language Summary
The Methodist Hospitals, Inc.

The Methodist Hospitals, Inc.
FINANCIAL ASSISTANCE POLICY SUMMARY

The Methodist Hospitals, Inc. ("Methodist") is dedicated to servicing the health care needs of its patients. To assist in meeting those needs, we have established a "Financial Assistance Policy" to provide financial relief to those patients who ask for assistance for medically necessary services and who are unable to meet their financial obligation. The Financial Assistance Policy applies to all Methodist's locations, employed physicians and physician extenders.

Applicants should have…
- Residence in the U.S.
- Limited or no health insurance (underinsured or uninsured)
- A household income at or below 400% of the current year's Federal Poverty Guidelines or incur a financially catastrophic balance

To uninsured patients, we offer emergency and other medically necessary services in our hospital at no charge to you if your income is at or below 200% of the Federal Poverty Guidelines (the "FPG"). Patients whose income is between 201 – 400% of FPG are eligible for sliding-scale financial relief. All applicants will be screened for other sources of payment to determine what level of financial assistance may be granted. All applicants must comply with the application process or meet presumptive charity requirements in order to receive financial assistance. If you are uninsured and are not eligible for financial assistance, you may still qualify for a discount under our Self-Pay Policy. Please request to speak with a financial counselor regarding the Self-Pay Policy.

If you have insurance, you may still qualify for financial assistance on your patient balance. The patient balance (when allowed for by the private insurer/employer plan) for emergency and other medically necessary services will be fully adjusted off if your income is at or below 200% of the Federal Poverty Guidelines (the "FPG"). Patients whose income is between 201 – 400% of FPG are eligible for sliding-scale financial relief. All applicants will be screened for other sources of income to determine what level of financial assistance may be granted. All applicants must comply with the application process in order to receive financial assistance.

If you have a Catastrophic Balance, which is defined as a balance due to Methodist which is greater than 25% of your annual family income as determined over a 12 month period, you may be eligible for financial assistance. Please ask to speak to a financial counselor for more details.

Under the financial assistance policy, you will not be billed more for emergency or other medically necessary care than the amount of the average payment percentage we are paid by Medicare.

You may apply for financial assistance at any time, even after services have been rendered; however, there are time limitations, as well as limitations to which services/accounts qualify for financial assistance—please see the full Financial Assistance Policy and/or request to speak to a financial counselor. You may obtain a free copy of the financial assistance policy and the financial assistance application form by the following methods: (1)on the Methodist Hospital website at **www.methodisthospitals.org/billing_info/obtaining-financial-assistance/** or (2)at our Northlake or Southlake campus in our admissions areas or emergency departments; or (3)by calling Financial Services at **219-886-4584 or 219-738-5508** to request that a free copy of our financial assistance policy and application form be mailed to you. You also have the option to set up an appointment with one of our financial counselors. Our financial counselors are here to assist you in completing the application—please reach out to them.

The financial assistance policy applies only to Methodist and for physician and physician extenders' services billed under Methodist's tax identification number. This policy does not apply to non-employed physicians and physician extenders who also treat patients at Methodist. A list of providers which are and are not covered by this policy is located in Appendix 3 of the Financial Assistance Policy.

Hay disponibles versiones en español de este documento, de la Política de Asistencia Financiera y de la Solicitud de asistencia financiera. Solicite copias gratuitas o visite www.methodisthospitals.org/ billing_info/obtaining-financial-assistance/.