Tri-State Pulmonary Associates, Inc.

Financial Hardship Policy

State and federal government guidelines or insurance contract requirements require us to bill patients for all balances that are determined to be owed unless a determination of financial hardship is made.

In the interest of making such a financial hardship determination, please complete the Financial Review Form. The purpose of this form is to enable us to evaluate the level of assistance we are able to extend to you in relation to your balance. If you are receiving financial discounts from The Christ Hospital or any other institution, please specify what level of discounting they are offering you. With the introduction of expanded Medicaid income criteria under the Accountable Care Act (Obamacare), all requests for Hardship involving services provided in 2014 must include a denial from your state's Medicaid program.

If a patient is deceased, we ask that the executor of the estate please contact us for resolution of any unpaid balance.

We will notify you as soon as a financial determination is made. Please contact our administrator, Marilyn Orr (513-419-1101) with any questions or concerns.

CONFIDENTIAL FINANCIAL WORKSHEET

Patient Name: _____ Responsible Party: _____
Address: _____ Social Security #:_____
City, State, Zip: _____ Date of Birth:_____
Telephone: _____ TSPA account #:_____
Cell Telephone: _____
Place of Employment:
Patient: _____ Spouse: _____
Number of persons living in your home: _____

MONTHLY INCOME
Patient's Income _____
Spouse's Income _____
Father's Income (if minor) _____
Mother's Income (if minor) _____
AFDC _____
Child Support _____
Social Security _____
Pension _____
SSI/Disability _____
Food Stamps _____
Other Income (please explain)
_____

MONTHLY EXPENSES
Rent/House Payment _____
Car/Truck Payments _____
Utilities (electric, phone, gas, water) _____
Car Insurance _____
Health/Dental Insurance _____
Life Insurance _____
Property Insurance _____
Property Tax _____
Medical Fees (Dr, Rx, Hospital) _____
Food/Clothing _____
Other (child care, bus, etc...) _____
Loan Payments (credit, school,etc)_____

TOTAL MONTHLY INCOME $ _____ **TOTAL MONTHLY EXPENSES $_____**

Remarks (use additional sheet, if necessary):_____

Name of PRIMARY Insurance Company_____ Policy #_____
Phone Number_____

Name of SECONDARY Insurance Company_____ Policy #_____
Phone Number_____

Have you applied for Ohio?IN/KY Medicaid? _____ MCD ID:_____
If yes, when:_____

I certify that the above information is true and accurate and that this application is made to enable TSPA, its parent, affiliates and/or subsidiaries to judge your eligibility for reduced out-of-pocket medical expenses. If any of the information given proves to be untrue, TSPA may re-evaluate your financial status and take action necessary to collect on your account.

Application Signature_____

Date_____

CRITERIA CONSIDERED IN REVIEWING FINANCIAL WORKSHEETS

1. Reasonableness/Prudent Measurement

a. Expenses relative to categories.
b. Housing obligations in relation to the area in which the beneficiary lives (*i.e.*, urban versus rural).
c. Income versus employment (*i.e.*, retired, disability, etc.)
d. Number of people in household versus expenses and type of expenses.
(1) Food
(2) Tuition/child care
(3) Rent versus own
(4) Clothing
(5) Other significant medical expenses

2. Allowable Cash Flow

a. Percentage of housing obligations, taxes and insurance to total income.
b. Percentage of total debt versus income.
c. Disposal income (*i.e.*, amount and percentage).
d. Net cash flow - income after taxes (*i.e.*, disposable income).
(1) Amount plus percentage are both considered (*i.e.*, 5% of $40,000 versus 5% of $10000)
e. Negative versus positive cash flow.
f. Other income.
(1) How much
(2) Type, *e.g.*, interest and dividends
(3) Total market value
g. Income level (*e.g.*, poverty level).
h. Government assistance (*e.g.*, food stamps, welfare, etc.)

Schedule for Waiver Request
Any family's income that is equal to or less than 200% of the National Poverty level will be approved for 100% waiver of all co-pays and deductibles. Poverty levels are determined by the U.S. Census Bureau.

FY 2013/2014 HHS Poverty Guidelines

Size of family unit	100 Percent of Poverty	110 Percent of Poverty	125 Percent of Poverty	150 Percent of Poverty	175 Percent of Poverty	185 Percent of Poverty	200 Percent of Poverty
1	$11,490	$12,639	$14,363	$17,235	$20,108	$21,257	$22,980
2	$15,510	$17,061	$19,388	$23,265	$27,143	$28,694	$31,020
3	$19,530	$21,483	$24,413	$29,295	$34,178	$36,131	$39,060
4	$23,550	$25,905	$29,438	$35,325	$41,213	$43,568	$47,100
5	$27,570	$30,327	$34,463	$41,355	$48,248	$51,005	$55,140
6	$31,590	$34,749	$39,488	$47,385	$55,283	$58,442	$63,180
7	$35,610	$39,171	$44,513	$53,415	$62,318	$65,879	$71,220
8	$39,630	$43,593	$49,538	$59,445	$69,353	$73,316	$79,260

For all states (except Alaska and Hawaii) and for the District of Columbia.

Note: For optional use in FFY 2012 and mandatory use in FFY 2013

For families that do not meet the above criteria, fees will be based upon their discretionary income. Discretionary income is defined as the difference between the family's total monthly (net) income and total monthly expenses.

Discretionary Income Monthly Payment
$ 0.00 - 200.00 Full Waiver
$201.00 - 250.00 $ 25.00
$251.00 - 300.00 $ 38.00
$301.00 - 350.00 $ 50.00
$351.00 - 400.00 $ 63.00
$401.00 - 450.00 $ 75.00
$451.00 - 500.00 $ 100.00