OTSEGO MEMORIAL HOSPITAL ASSISTANCE PROGRAM

Under its assistance program Otsego Memorial Hospital will make available a reasonable amount of uncompensated or reduced price services to persons eligible under applicable guidelines. Otsego Memorial Hospital Assistance Program services are not limited to any specific hospital service. Individual eligibility for assistance is determined by measuring family income in relation to family size against the income poverty guideline established by the Community Service Administration. The current income requirements for assistance are listed below:

Discount %	95-100%	85%	75%	50%
1	$12,140 – 18,210	$18,211 - $24,280	$24,281 - $30,350	$30,351 - $42,490
2	$16,460 - $24,690	$24,691 - $32,920	$32,921 - $41,150	$41,151 - $57,610
3	$20,780 - $31,170	$31,171 - $41,560	$41,561 - $51,950	$51,951 - $72,730
4	$25,100 - $37,650	$37,651 - $50,200	$50,201 - $62,750	$62,751 - $87,850
5	$29,420 - $44,130	$44,131 - $58,840	$58,841 - $73,550	$73,551 - $102,970
6	$33,740 - $50,610	$50,611 - $67,480	$67,481 - $84,350	$84,351 - $118,090
7	$38,060 - $57,090	$57,091 - $76,120	$76,121 - $95,150	$95,150 – $133,210

If you think you may be eligible for assistance, you should return the enclosed form or contact the Business Office during normal business hours, Monday thru Friday between the hours of 8:00 a.m. and 4:00 p.m.

- **Hospital bills last name starts with A-L 989-731-2200**
- **Hospital bills last name starts with M-Z 989-731-6228**
- **Physician bills 989-731-7774**

A determination will be made within one (1) week of receipt if all pertinent information is returned with the application. The following documents are required:

***<u>Proof of current Health Insurance AND Medicaid denial for secondary insurance coverage</u>**
OR
***<u>Medicaid Insurance information including any monthly deductible / spendown amounts</u>**

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Tax Return & W-2's (Federal)**
***Four (4) most recent pay stubs.**
***Cash or Food Assistance through DHS**

Any balance owed by you after the plan discount must be paid or your assistance will be discontinued and you will no longer be eligible to apply for future benefits.
1/17/2018 REVISED

Otsego Memorial Hospital
Financial Assistance Application

Deadline for receipt of Financial Assistance Application for services – The later of: 30 days after the date written notice of financial assistance is provided, or 240 days after the first post-discharge billing statement for previous care. Application and requested documentation must be returned within 14 calendar days.

I. RESPONSIBLE PARTY					
LAST NAME	FIRST NAME		MI	MARITAL STATUS	SOCIAL SECURITY #
STREET ADDRESS					
CITY	STATE	ZIP	HOW LONG AT THIS ADDRESS?		HOME PHONE
EMPLOYER'S NAME AND ADDRESS				YEARS EMPLOYED	DATE OF BIRTH

II. SPOUSE OR SIGNIFICANT OTHER		
NAME		SOCIAL SECURITY #
EMPLOYER'S NAME AND ADDRESS	YEARS EMPLOYED	DATE OF BIRTH

III. HOUSEHOLD INFORMATION (ALL OTHER PERSONS IN HOUSEHOLD)		
NAME	DOB	RELATIONSHIP
TOTAL PERSONS IN HOUSEHOLD:		

IV. MONTHLY INCOME		
RESPONSBLE PARTY'S MONTHLY INCOME		$
SPOUSE/SIGNIFICANT OTHER'S MONTHLY INCOME	+	$
TOTAL MONTHLY INCOME:	**=**	**$**

V. MEDICAID APPLICATION (CHECK APPROPRIATE ANSWER)	Approved _____ Denied_____
FILL IN SPENDDOWN AMOUNT IF APPLICABLE	APPROVED SPENDDOWN AMOUNT _____

VI. MISCELLANEOUS INCOME PER MONTH – complete All fields with gross monthly amount or N/A if not applicable			
DIVIDENDS, INTEREST	$	PENSIONS	$
PUBLIC ASSISTANCE/FOOD STAMPS	$	INVESTMENT/RENTAL INCOME	$
SOCIAL SECURITY	$	GRANTS	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	Other	$
CHILD SUPPORT/ALIMONY	$		
TOTAL MONTHLY MISCELLANEOUS INCOME:	$		
MONTHLY INCOME:	+		$
TOTAL MONTHLY INCOME:	**= $**	**ANNUAL:**	**$**

ALL INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED AND FOLLOW THE PROCEDURE GUIDELINES DEFINED IN THE FINANCIAL ASSISTANCE POLICY UNDER PROCEDURE: section 2, paragraph E.

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY {HOSPITAL NAME} OR ITS AGENTS.

SIGNATURE/ DATE: _____/_____

RELATIONSHIP IF OTHER THAN PATIENT: _____

FOR OFFICE USE ONLY			
APPROVED/DENIED	%	$	DATE:
APPROVED BY:			

Approved applications will be effective for services covered according to Financial Assistance Policy guidelines for up to six (6) months from the approval date.

The following documents are required (if applicable):

`*<u>Proof of current Health Insurance AND Medicaid denial for secondary insurance coverage</u>

OR

***<u>Medicaid Insurance information including any monthly deductible / spendown amounts</u>**

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Tax Return & W-2's (Federal)**
***Four (4) most recent pay stubs.**
***Cash or Food Assistance through DHS**

OTSEGO MEMORIAL HOSPITAL ASSISTANCE PROGRAM
Financial Assistance Policy – Plain Language Summary

Otsego Memorial Hospital (OMH) and OMH Medical Group's Financial Assistance Policy (FAP), exists to provide eligible patients partial or fully discounted emergent or medically necessary care. Patients who will be seeking Financial Assistance must apply for the program, which is summarized below.

Eligible Services – Emergent and/or medically necessary healthcare services provided by OMH and OMH Medical Group providers. The services only include services billed by OMH or OMH Medical Group. Other services, such as Pathology, physicians not employed by OMH and radiology interpretations provided by an organization other than OMH, are not eligible under the FAP.

Eligible Patients – Patients receiving Eligible Services, who submit a completed Financial Assistance Application including all required documentation/information, and who are determined to be eligible for Financial Assistance according to the policy guidelines.

How to Apply – Financial Assistance Applications (including Plain Language and full Financial Assistance Policy) may be obtained /completed/submitted as follows:

- Obtain an application at the hospital Information Desk or at the front desk of any Hospital owned clinic.
- Request an application be mailed to you, by calling 989-731-7777 for Physician or 989-731-2198 for Hospital Billing.
- Request an application by visiting in person: OMH Administrative Services Building, 271 W. McCoy Rd., Gaylord, MI 49735.
- Download an application from the OMH website at: www.myomh.org/patient-assistance-program
- Mail Completed applications (with all required documentation/information specified in the application instructions) to OMH Financial Assistance, 271 W. McCoy Rd., Gaylord, MI 49735. Specify hospital assistance of physician assistance.

Determination of Financial Assistance Eligibility – Generally, Eligible persons are eligible for Financial Assistance using a sliding scale, when their family income is at or below 350% of the Federal Government's Federal Poverty Guidelines (FPG). Eligibility for Financial Assistance means that Eligible persons will have their care fully covered or partially, and they will not be billed more than "Amounts Generally Billed" (AGB) to insured persons (AGB, as defined by IRS Section 501(r)). Financial Assistance levels based solely on Family income and FPG are:

FPG	0 to 100	100 to 150%	150% to 200%	200% to 250%	250% to 300%	300% to 350%
Discount %	100%	95%	85%	75%	50%	50%

Note: Other criteria beyond the FPG are also considered, including: The availability of other program coverage for the services; Medicaid denial or prior consultation with our Certified Application Counselor (CAC); residence within the OMH immediate service area; management discretion.

The following documents are required if applicable:

**Proof of current Health Insurance AND Medicaid denial for secondary insurance coverage*

OR

**Medicaid Insurance information including any monthly deductible / spendown amounts*

**SSA 1099 (Social Security proof)*
**Child Support/Spousal Support*
**Cash or Food Assistance (DHS)*
**Pension Proof*
** Federal Tax Return & W-2's*
**Unemployment Proof*
**Four (4) most recent pay stubs.*

A determination will be made within one (1) week of receipt if all pertinent information is returned with the application.

For questions or help: Call Hospital Billing during normal business hours, Monday thru Friday between the hours of 8:00 a.m. and 4:00 p.m. at 989-731-2200 or 800-322-3664 ext. 2200 if your last name starts with A-L, or 989-731-6228 or 800-322-3664 ext. 6228 if your last name starts with M-Z; for Physician Billing call 989-731-7777.