

Effective Date: March 15, 2022  
Approved: Debra Ridenour/Charles Wiley

Reviewed Date: March 15, 2022

---

Harrison County Hospital has a tradition of serving the poor, the needy, and all who require health care services. In order to promote the health and well-being of the community served, individuals with limited financial resources shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon Federal Poverty guidelines. The need for financial assistance is based on income and may be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When an account that is closed is to be reopened, or
- When the last financial evaluation was completed more than six months before.

Appropriate signage will be visible in the facility, specifically in patient intake areas, creating awareness for the financial assistance program and the assistance available. Information, such as brochures, will be included in patient services/information folders and/or in patient intake areas. The Financial Assistance Policy and Application is available on our website, [www.hchin.org](http://www.hchin.org), under Important Information. Paper copies of the Financial Assistance Application are visually placed in the main registration areas, are handed out to all uninsured patients during registration, and publically advertised one time a year on the hospital's Facebook page. In addition each statement includes a contact phone number to request a copy of the Financial Assistance Application and/or Policy. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area.

The necessity for medical treatment for any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

#### **SPECIAL INSTRUCTIONS / GUIDELINES / FORMS TO BE USED**

Cover Letter for Application, Application, Authorization to Release Information	(Attachment # 1)
My Income was Below the Federal and State Filing Requirements Form	(Attachment # 2)
Request for Verification of Bank Accounts	(Attachment # 3)
Financial Assistance Worksheet For Hospital	(Attachment # 4)
Catastrophic Financial Assistance Worksheet – Hospital Only	(Attachment # 5)
Final Request for Documentation Letter	(Attachment # 6)
Denial Letter	(Attachment # 7)
Confirmation of Social Security Exemption	(Attachment # 8)
Final Determination of Eligibility Letter	(Attachment # 9)
Payment Plan Letter	(Attachment # 10)

#### **I. DEFINITIONS**

- Available Financial Resources:** Include assets that are immediately available, cash and investments such as savings, checking as well as other investments.
- Financial Assistance Committee:** A committee consisting of the Chief Financial Officer, Patient Accounts Manager, Business Office Coordinator, Financial Counselor and Patient Advocate, Designated Medicaid Eligibility Representative(s).
- Household:** The patient, his/her spouse and his/her legal dependents according to the Internal Revenue Service rules. We reserve the right to require documentation but do not include income or assets of dependent age 18 or younger.

- D. Presumptive Eligibility: When a patient is presumed to be eligible for financial assistance without being required to submit an application for financial assistance, based on factors such as being homeless, being eligible for federal, state or local assistance programs, (food stamps, federally subsidized school lunch program, low income or subsidized housing), or receiving free care from a community clinic.**

**II. FINANCIAL ASSISTANCE GUIDELINES**

- A. To be eligible for full financial assistance the household income must be at or below 200 percent of the current Federal Poverty Guidelines or be deemed to be presumptively eligible based on established criteria.**
- B. To be eligible for partial financial assistance (75 percent reduction of the patient portion of billed charges) a financially indigent patient's household income must be at or below 300 percent but more than 200 percent the Federal Poverty Guidelines.**
- C. Following the determination of eligibility for financial assistance you will not be charged more than the hospital's Amount Generally Billed (AGB) using the look back method. The hospital's AGB discount percentage is 66% and explanation of how it is calculated is available from the Finance department on request.**
- D. To be eligible for full or partial financial assistance an indigent patient must be a U. S. Citizen or in the country legally, and residing within either Harrison or Crawford County, Indiana or Meade County, Kentucky, or have an established relationship with a physician who is a member of the Harrison County Hospital medical staff. Patients' visits to Harrison County Hospital due to a medical emergency are eligible to apply for full or partial financial assistance, regardless of person's race, color, religion, sex, national origin, age, disability or genetic information.**
- E. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.**
- F. To be considered for financial assistance, the patient must cooperate with the designated hospital representatives to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as, Medicare, Medicaid, HIP, COBRA, QMB, etc. To be eligible for assistance, the patient must apply for available government coverage such as Medicare Part B. If the patient is denied financial assistance related to failure to cooperate with Harrison County Hospital or government/state guidelines, they must wait 90 days from date of denial letter to reapply and previous accounts will not be eligible. Accounts originally classified as bad debts may be subsequently eligible for financial assistance for up to three years if not in legal collection status. If the patient is approved for assistance, a refund for the patient amount paid may be requested up to 180 days from the date the payment was posted, less collection fees.**
- G. Financial Assistance approval will be effective for six months or until a change in patient financial status is determined or is revoked due to non-cooperation. Hospital reserves the right to request additional information from patient during this six month period. It is the patient's responsibility to notify hospital staff of accounts with balances that may be eligible for assistance.**
- H. Harrison County Hospital recognizes the fact that there may be instances in which a patient's income exceeds the previously mentioned guidelines, but the patient's medical expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burdens. Financial assistance may also be appropriate for these individuals.**

- I. This policy will also apply to services provided by all hospital employed physicians, if the place of service is Harrison County Hospital.

### **III. IDENTIFICATION OF POTENTIALLY ELIGIBLE PATIENTS**

- A. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process for up to 24 months following the date of service. Patients who are assigned to a hospital contracted collection agency may also be screened by that agency for financial assistance, with qualified recipients being reported to the hospital at least every 30 days. If the account is in collections at time of approval, agency fees may be deducted from any refund due patient.
- B. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.
- C. Patients applying for financial assistance where it is reasonably believed they would qualify for a government financial assistance program (such as Medicaid or HIP) but do not apply due to religious beliefs, will be financially responsible for 15% of total charges on outpatient encounters and DRG Medicaid reimbursement rate on inpatient encounters. The patient should complete a written Application for Financial Assistance and submit Attachment # 8 (Confirmation of Social Security Exemption).

### **IV. DETERMINATION OF ELIGIBILITY**

- A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. Information on the availability of financial assistance is also included on every statement/bill sent to a self-pay patient.
- B. The person requesting financial assistance should complete a written Application. For Financial Assistance (Attachment # 1) a completed application and supporting data should be returned to the Financial Counselor for evaluation. If the patient is food stamp, TANF or Medicaid eligible and can provide proof of eligibility then the need for other supporting data will be waived.
- C. In the evaluation of an application for financial assistance, a patient's total household income and available financial resources will be taken into account. The amount of financial assistance to be provided will be reduced by any available resources in excess of \$6,000 for an individual and increased by \$2,000 for each individual household member.
- D. **Presumptive Eligibility:** At Harrison County Hospital's discretion, Financial Assistance may also be considered and granted without completion of a Financial Assistance Application. Harrison County Hospital may refer to or rely on the following external factors and/or other program enrollment resources to determine patient's eligibility:
- Patient is homeless
  - Patient is eligible for other funded federal state or local assistance programs
  - Patient is eligible for state or local assistance programs
  - Patient is eligible for food stamps or federally subsidized school lunch program
  - Patient is eligible for a state-funded prescription medication program
  - Patient's valid address is considered low-income subsidized housing
  - Patient receives free care from a community clinic and is referred to hospital for further treatment
  - The patient expires and there is insufficient money in the estate or no estate to pay the patient's HCH bill.
  - Patients who are deemed presumptively eligible for Financial Assistance may receive an adjustment to their account and may only be eligible on a specific date of service

- E. **Harrison County Hospital will not look to force liquidation of a personal residence, but may file a lien to protect our interest through future sale of such property. A credit report may also be generated.**
- F. **Financial assistance approvals for amounts greater than \$10,000 should be approved by the Patient Accounts Manager. Those greater than \$25,000 should be approved by the CFO. The Financial Counselor shall notify the patient of the outcome.**
- G. **Accounts where patients are identified as medically indigent or accounts where the collector or Patient Accounts Manager has identified special circumstances that when taken into consideration may affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination.**

**V. NOTIFICATION OF ELIGIBILITY DETERMINATION**

- A. **Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. A prompt turnaround and a written decision to the patient, which provides a reason for denial, will be provided, generally within ten (10) days of the application process utilizing the Final Determination of Eligibility Letter (Attachment # 9). Applicants denied financial assistance may qualify for an extended interest free payment plan approved by the Patient Accounts Manager, not to exceed 18 months.**

**VI. POLICY COMPLIANCE BY SERVICE LINE**

- A. **Collection activity may be suspended during the consideration of a financial assistance application. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be set up based on billing and collection policy. Actions to be taken by the hospital in the event of nonpayment are described in the billing and collections policy.**
- B. **A free copy of the Billing and Collection Policy can be obtained by calling 812-738-8755.**

**FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR HOSPITAL**

**Based upon Federal Poverty Guidelines, Gross income levels, 2021 (AGB discount 66% July 2021)**

Family Size	100%	75%
1	0-25,760	25,761-38,640
2	0-33,840	33,841-52,260
3	0-43,920	43,921-65,880
4	0-53,000	53,001-79,500
5	0-62,080	62,081-93,120
6	0-71,160	71,161-106,740
7	0-80,240	82,241-120,360
8	0-89,320	89,321-133,980
Each Additional	9,080	13,260

List of Providers **Covered** by Financial Assistance Policy  
**In** Harrison County Hospital Services Only

Anesthetists  
Hospitalists  
Orthopedic Surgeon  
Podiatrist  
Pediatricians

**PROVIDER BASED OFFICES**

Institutional Claims Only  
Corydon Medical Associates  
Dermatology & Skin Cancer Center  
First Capital Medical Group  
General Surgery Associates  
Harrison Crawford Healthcare  
HCH Pain Management  
HCH OB/GYN  
Kids First Pediatrics  
Orthopedic Surgeons of Harrison County  
South Harrison Family Medicine

List of Providers **Not Covered** by Financial Assistance Policy  
Services of physicians, groups of physicians or other  
practitioners that are not employed by the hospital,  
including but not limited to  
SCP Health – Emergency Room Physicians  
Radiology Associates – Radiology Group  
Women’s Healthcare of Southern Indiana – Dr. Dunn, OB/GYN  
Norton Specialty Groups – Oncology, Cardiovascular,  
Gastroenterology, Vascular



An affiliate of  
NORTON HEALTHCARE

FINANCIAL DOCUMENTATION REQUIRED FOR ALL  
MEMBERS OF THE HOUSEHOLD

Date: \_\_\_\_\_

Dear Patient,

In an effort to assist you with your medical expenses at Harrison County Hospital, an application for financial assistance is enclosed. Please **complete the application** and **provide copies** of the documentation checked below.

**You may be contacted by a representative from an outside agency (ClaimAid or Complete Billing Services) who work with the hospital, to see if you are eligible for other payment sources that may be available. Failure to cooperate with one of these outside agencies will result in a denial of financial assistance.**

**For the application to be considered, you MUST return the following documents:  
(Your application cannot be processed for consideration if the requested documentation is not included.)**

\_\_X\_\_ Food Stamps or TANF ***\*If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.\****

\_\_X\_\_ Federal Tax Return (1040) for the most recent year (or IRS Form 4506-T).

\_\_X\_\_ Last Three Months of Financial Information:  
(Checking, Savings and Investments - *please include all pages of each statement*)

\_\_X\_\_ Pay Stubs for the last 13 weeks for patient and spouse (or last 7 bi-weekly pay stubs), if income has changed since previous year's tax return.

\_\_X\_\_ Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc.).

\_\_X\_\_ **Other:** If either you or your spouse have no income then that person must submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.

Other: \_\_\_\_\_

Please return materials **by mail or fax (812) 738-8780** within 10 days or call me **to schedule an appointment to copy and review** the information. If you have any questions, please feel free to call me **at (812) 738-7846**.

Thank you,

*Stephanie Lovings*  
Financial Counselor

1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

**APPLICATION FOR FINANCIAL ASSISTANCE**

**ACCOUNT #** \_\_\_\_\_

I hereby request that Harrison County Hospital make a written determination of my eligibility for financial assistance services. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by this Hospital. I also understand that if the information, which I submit, is determined to be false, such a determination will result in a denial of financial assistance and that I will be liable for charges for services provided.

**PLEASE PRINT**

**1. GUARANTOR (person responsible for payment)**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  
           Last                      First                      MI  
 Address: \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_  
           Number and Street              City              State              Zip  
 County: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

**2. EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_**

Address: \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_  
           Number and Street              City              State              Zip

**3. PATIENT'S information if different than Guarantor**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  
           Last                      First                      MI  
 Address: \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_  
           Number and Street              City                      State              Zip

**4. PATIENT'S Spouse**

Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Social Security #: \_\_\_\_\_  
           Last                      First                      MI  
 Address: \_\_\_\_\_ Phone #(\_\_\_\_\_) \_\_\_\_\_  
           Number and Street              City                      State              Zip

SPOUSE'S EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

5. Has guarantor filed bankruptcy in the last 12 months?   Yes    No

**6. FAMILY SIZE \_\_\_\_\_ (All persons claimed on tax return)**

**7. INCOME: List income for all the family members claimed on your tax return. *Attach proof of the supporting income***

NAME	RELATIONSHIP	AGE	NAME	RELATIONSHIP	AGE
1.			5.		
2.			6.		

3.	7.
4.	8.

**APPLICATION FOR FINANCIAL ASSISTANCE** *continued*

**8. TOTAL AMT. FOR LAST 13 WEEKS**

Gross Wage	\$ _____
Self-Employment or Personal	\$ _____
TANF Benefits	\$ _____
Food Stamps Benefits	\$ _____
Social Security/Disability	\$ _____
Unemployment Compensation	\$ _____
Worker's Compensation	\$ _____
Child Support	\$ _____
Pensions	\$ _____
Income from Dividends, Interest, or Rental	\$ _____
Other (Please Explain)	\$ _____

**TOTALS \$** \_\_\_\_\_

**9. ASSETS** (please provide copies for last 3 months)

\$ \_\_\_\_\_ Checking Acct Balance

Financial Institution Name: \_\_\_\_\_

\$ \_\_\_\_\_ Saving Acct Balance

Institution Name: \_\_\_\_\_

\$ \_\_\_\_\_ Investments (Stocks, Bonds, Mutual Funds, Money Market Account(s), CD's)

\$ \_\_\_\_\_ Other Assets (please describe)

\$ \_\_\_\_\_ **TOTAL ASSETS**

**FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR HOSPITAL**

Based upon Federal Poverty Guidelines, Gross income levels, 2021

Family Size	100%	75%
1	0-25,760	25,761-38,640
2	0-33,840	33,841-52,260
3	0-43,920	43,921-65,880
4	0-53,000	53,001-79,500
5	0-62,080	62,081-93,120
6	0-71,160	71,161-106,740
7	0-80,240	82,241-120,360



<b>8</b>	<b>0-89,320</b>	<b>89,321-133,980</b>
<b>Each Additional</b>	<b>9,080</b>	<b>13,260</b>

## AUTHORIZATION TO RELEASE INFORMATION

The undersigned certifies the following:

1. Patient and/or guardian has applied for financial assistance with Harrison County Hospital and as part of the application process, it is understood that Harrison County Hospital may verify information contained in patient and/ or responsible party's application and in other documents such as the patient's credit report which may have been supplied in connection with the financial assistance application.
  
2. Patient and/or responsible party duly authorize you to release and provide to Harrison County Hospital any and all information and documentation that they may request. I give permission to Harrison County Hospital to discuss any accounts that are in the patient and/or guardian's name.
  
3. A photo or faxed copy of this authorization may be accepted as an original.

\_\_\_\_\_  
Printed Patient's or Responsible Party Name

\_\_\_\_\_  
Patient's or Responsible Party Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Spouse/Other's Name

\_\_\_\_\_  
Spouse/Other's Signature

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Date

**I understand that the information which I submit is subject to verification by Hospital. I certify that the above information is true, correct, and complete.**



**Date:** \_\_\_\_\_

**My income was below the federal and state filing requirements, therefore; I did not file a tax return in the year \_\_\_\_\_.**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Spouse's Signature**

\_\_\_\_\_  
**Date**



An affiliate of  
 NORTON HEALTHCARE

### Request for Verification of Bank Accounts

Institution: \_\_\_\_\_ Date: \_\_\_\_\_

Customer: \_\_\_\_\_ SSN #: \_\_\_\_\_

I give my permission to the above institution to provide Harrison County Hospital the information requested below via mail or fax. This permission expires one year after the date I sign this form.

Signature	Date
-----------	------

This information is required to determine eligibility for a medical assistance program of eligibility and released only to the governing agency that makes the determination. The information given will be kept confidential. Please return this completed form **within 10 days** to:

**Harrison County Hospital**  
**Attn: Stephanie Lovings**  
**1141 Hospital Dr. NW**  
**Corydon, IN 47112**  
**812-738-7846**

**FAX 812-738-8780**

**Please complete all requested information below OR provide statements covering these dates**

Acct Type (Ch, Sa, CD, Other)	Last 2 Acct #	Balance Date	Balance Date	Amount, Date & Frequency of Last Interest Payment (monthly, etc.)	Other Names on Acct.

Closure of Accounts?     YES    NO    Date and Balance at Closure: \_\_\_\_\_

Account Number: \_\_\_\_\_

Typed Name or Stamp of financial institution	Signature and Title of Officer	Date Signed
--	--------------------------------	-------------

**Harrison County Hospital****FINANCIAL ASSISTANCE WORKSHEET FOR HOSPITAL****(FOR FINANCE OFFICE USE ONLY)****Application Date** \_\_\_\_\_**Name of Applicant** \_\_\_\_\_ **Phone #** \_\_\_\_\_**Account #(s)** \_\_\_\_\_**Balance \$** \_\_\_\_\_**Annual Household Income \$** \_\_\_\_\_**Total Available Financial Resources \$** \_\_\_\_\_**Credit Report Available**    **Yes**    **No****Percentage Financial Assistance per Guidelines** \_\_\_\_\_**Amount Approved \$** \_\_\_\_\_**Date of Determination** \_\_\_\_\_**Approved By** \_\_\_\_\_ **Date** \_\_\_\_\_**Denied By** \_\_\_\_\_ **Date** \_\_\_\_\_**Referred To:****Patient Accts Mgr** \_\_\_\_\_ **CFO** \_\_\_\_\_ **Financial Assistance Committee** \_\_\_\_\_**FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA FOR HOSPITAL****Based upon Federal Poverty Guidelines, Gross income levels, 2021**

<b>Family Size</b>	<b>100%</b>	<b>75%</b>
<b>1</b>	<b>0-25,760</b>	<b>25,761-38,640</b>
<b>2</b>	<b>0-33,840</b>	<b>33,841-52,260</b>
<b>3</b>	<b>0-43,920</b>	<b>43,921-65,880</b>
<b>4</b>	<b>0-53,000</b>	<b>53,001-79,500</b>
<b>5</b>	<b>0-62,080</b>	<b>62,081-93,120</b>
<b>6</b>	<b>0-71,160</b>	<b>71,161-106,740</b>
<b>7</b>	<b>0-80,240</b>	<b>82,241-120,360</b>
<b>8</b>	<b>0-89,320</b>	<b>89,321-133,980</b>
<b>Each Additional</b>	<b>9,080</b>	<b>13,260</b>

**Harrison County Hospital**

**CATASTROPHIC FINANCIAL ASSISTANCE WORKSHEET – HOSPITAL ONLY**

(FOR FINANCE OFFICE USE ONLY)

NAME OF APPLICANT \_\_\_\_\_ APPLICANT PHONE # \_\_\_\_\_

ACCOUNT #(S) \_\_\_\_\_ BALANCE \$ \_\_\_\_\_

TOTAL AMOUNT REQUESTED \$ \_\_\_\_\_ CREDIT REPORT AVAILABLE YES NO

DATE REQUESTED \_\_\_\_\_ DATE REFERRED TO FINANCIAL ASSISTANCE COMMITTEE \_\_\_\_\_

GROSS VALUE OF HOME AND OTHER REAL ESTATE \$ \_\_\_\_\_

LESS RELATED DEBT \$ \_\_\_\_\_

NET VALUE OF HOME AND OTHER REAL ESTATE \$ \_\_\_\_\_

ANY OTHER EXTENUATING CIRCUMSTANCES: \_\_\_\_\_

<u>CATASTROPHIC FINANCIAL ASSISTANCE CALCULATION PROCESS</u>	<u>12 Month Period</u>
<b>Time Period Covered</b>	_____ - _____ mm/dd/yy                      mm/dd/yy
<b>Total Household Income</b>	A. _____
<b>Income Factor</b>	B.                      x 25%
<b>Income Threshold</b>	C. _____
	(A x B)
<b>Total HCH Hospital Bills</b>	D. _____
(After all 3 <sup>rd</sup> Party Payments, excluding financial assistance adjustment)	(12 mo.)
<b>Total Other Medical Bills</b>	E. _____
(After all 3 <sup>rd</sup> Party Payments, if any)	(12 mo.)
<b>Total Medical Bills</b>	F. _____
	(D + E)
<b>Medical Bills in Excess of Income Threshold</b>	G. _____
(If number is negative, does not qualify)	(F - C)
<b>Catastrophic Financial Assistance Allocation Factor</b>	H. _____
	(D ÷ F)
<b>Maximum Allowable Catastrophic Financial Assistance</b>	I. _____
If greater than zero, then greater of amount on I or 65%	(H x G)

**DETERMINATION**

AMOUNT APPROVED \$ \_\_\_\_\_ DATE OF DETERMINATION \_\_\_\_\_

APPROVED BY \_\_\_\_\_ DATE \_\_\_\_\_

DENIED BY \_\_\_\_\_ DATE \_\_\_\_\_

REASON DENIED \_\_\_\_\_



**FINAL REQUEST FOR DOCUMENTATION**

**Final Request for Documentation**

**Date:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dear** \_\_\_\_\_,

**Your application for financial assistance was received. The following required documentation was not included. Please return your documentation within 10 days or your application will be denied and you must wait at least 90 days before re-applying**  
**\_\_\_\_\_ Food Stamps or TANF: \*If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.\***

\_\_\_\_\_ **Federal Tax Return (1040) for the most recent year (or IRS Form 4506-T)**

\_\_\_\_\_ **Last Three Months of Financial Information (Checking, Savings and CD's)**

\_\_\_\_\_ **Pay Stubs for the last 13 weeks (or last 7 bi-weekly pay stubs), if income has changed since previous year's tax return.**

\_\_\_\_\_ **Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc...)**

\_\_\_\_\_ **Other: If you have no income submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.**

**Other:** \_\_\_\_\_

If you have any questions, please feel free to call me **at (812) 738-7846.**

**Thank you,**

***Stephanie Lovings***  
**Financial Counselor**



Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dear \_\_\_\_\_,

**We have reviewed your request for Financial Assistance with Harrison County Hospital. Your request is denied due to the amount of your income and/or available financial resources.**

**Thank you for considering Harrison County Hospital. If you have any questions or concerns please do not hesitate to call.**

**Thank you,**

***Stephanie Lovings***  
**Financial Counselor**





An affiliate of  
NORTON HEALTHCARE

Date: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dear \_\_\_\_\_,

**In an effort to assist you with your medical expenses at Harrison County Hospital, please respond to the information below.**

**I am unable to apply for Medicaid or have no social security number for the following reason:**

**Due to religious beliefs**

**If so, please explain:**

**Please provide a letter from a local leader of your religious order for confirmation.**

\_\_\_\_\_

**Not a U.S. citizen**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

**Thank you,**

***Stephanie Lovings***  
**Financial Counselor**



**FINAL DETERMINATION  
OF ELIGIBILITY**

**Application Date:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Dear** \_\_\_\_\_,

**Your request for financial assistance has been reviewed and the determination is as follows:**

\_\_\_\_\_ **Your request for uncompensated care has been denied because your income exceeds the income criteria specified under the Federal Poverty Guidelines.**

\_\_\_\_\_ **Partial Approval - you owe only \$\_\_\_\_\_ on your account(s).**

\_\_\_\_\_ **100 % Approval - You owe nothing on your account (s).**

\_\_\_\_\_ **Other:** \_\_\_\_\_  
Unfavorable decision may be appealed in writing to my attention at the address below within 20 days after the date of this letter. Catastrophic medical expenses can be introduced during this appeal.

**Patients are responsible for contacting any other agencies regarding their billing and policies. Harrison County Hospital only reviews and makes determination for charity for Harrison County Hospital patients' accounts.**

**This eligibility determination covers the following services only. If you have any other hospital account not listed below please contact me.**

Account #	Date of Service	Amount Approved	Balance Due		Account #	Date of Service	Amount Approved	Balance Due

**TOTAL CHARGES:** \$ \_\_\_\_\_

**TOTAL FINANCIAL ASSISTANCE APPROVED:** \$ \_\_\_\_\_

**TOTAL ACCOUNT (S) BALANCE DUE:** \$ \_\_\_\_\_

**If you are unable to pay the discounted amount in full, please call (812) 738-7846 immediately to set up payment arrangements. Thank you.**

**Sincerely,**  
**Stephanie Lovings**  
**Financial Counselor**

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_



An affiliate of  
NORTON HEALTHCARE

Date: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Dear \_\_\_\_\_,

Thank you for choosing Harrison County Hospital for your Healthcare Needs.

We understand that with the financial challenges that many are facing with today's economy you may not be able to pay for your procedure in full at the time of service.

Account # \_\_\_\_\_

You agree to pay a deposit amount of \$ \_\_\_\_\_.

You agree to make a monthly payment of \$ \_\_\_\_\_ due on the \_\_\_\_\_ of each month until the balance is paid in full.

The estimated balance for your procedure is \_\_\_\_\_. This estimate is based on the average cost of this procedure without any unforeseen complications. In the event there are complications, you will be notified and billed.

Your next payment is due on \_\_\_\_\_.

Please sign below to signify that you agree to pay this account as stated above.

X \_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

If you have any questions, please feel free to contact me at 812-738-7846.  
Thank you,

*Stephanie Lovings*  
Financial Counselor  
Harrison County Hospital