HUTCHINSON HEALTH
FINANCIAL ASSISTANCE PROGRAM

Thank you for your interest in Hutchinson Health's Financial Assistance Program. We strive to provide quality, affordable care for all of our patients and are committed to providing financial assistance to uninsured and underinsured individuals in need of medically necessary care.

Enclosed you will find the Charity Care application and instructions. For your convenience, below is a brief summary of the requirements to qualify for Charity Care.

To be eligible for Charity Care, patients who are uninsured or underinsured must:

- Have received medically necessary eligible services delivered through Hutchinson Health that are covered under this program.
    - Cooperate with your Worker's Compensation, auto or any other insurance carrier requirements. Applicants must cooperate with the rules of their insurance policy which includes responding to all insurance inquiries within time frames allowed by their insurance carrier(s).

- Have applied for Medical Assistance and provided proof of eligibility or denial (only required for uninsured patients)
- Have an annual gross income at or below 400% of the federal poverty level (FPL) as outlined in the table below.
- Have assets under $20,000.
- Have completed the financial assistance application and provided all supporting documentation
    - The accounts of deceased patients who have no known estate and no surviving spouse will be determined uncollectible and eligible for the Charity Care without the completion of an application

2018 Income Level Eligibility Guidelines for the Charity Care Program			
		Free Care if income is not more than	**50% discount if income is not more than**
Family Size	Annual Gross Income at 100% of FPL	Annual Gross Income at 200% of FPL	Annual Gross Income at 400% of FPL
1	$12,140	$24,280	$48,560
2	$16,460	$32,920	$65,840
3	$20,780	$41,560	$83,120
4	$25,100	$50,200	$100,400
5	$29,420	$58,840	$117,680
6	$33,740	$67,480	$134,960
7	$38,060	$76,120	$152,240
8	$42,380	$84,760	$169,520
*	$4,320	$8,640	$17,280
*For families/households with more than 8 persons, add $4,320, $8,640 and $17,280 respectively to the annual incomes listed above for each additional member.			

If you have any questions as you complete the Charity Care application, our contact information is listed in Section II of the attached instructions. We would enjoy the opportunity to assist you through this process.

Thank you for choosing Hutchinson Health for your healthcare needs.

Hutchinson Health
Charity Care Application

IMPORTANT:

- Be sure to complete the entire application and answer all of the questions.
- Attach copies of all requested documents (do not send originals).
- Sign and date the application and return to Hutchinson Health within 30 days of the date received.
- Your application may be denied if all required information is not submitted.
- If you are unsure of what documentation to include or you need any assistance with this application, please contact us as follows:
  - By phone - call 320-484-4493 or 800-454-3903 to reach a Patient Financial Advocate.
  - In person – present application to a Patient Financial Advocate at Hutchinson Health, 1095 Highway 15 South, Hutchinson, MN 55350. (Please stop at the main entrance desk or any registration desk for directions to the Patient Financial Advocate offices.)

1. PRIMARY APPLICANT (If applying for a minor child, enter YOUR name here, and list the child as a dependent in Section 2 below)

FIRST NAME	M.I.	LAST NAME	DATE OF BIRTH	SEX ☐M ☐F	MARITAL STATUS

STREET ADDRESS	CITY	STATE	ZIP CODE

Are you a U.S. Citizen? ☐Yes ☐No	IF YES, SOCIAL SECURITY NUMBER (OPTIONAL)	HOME PHONE	OTHER PHONE

2. OTHERS LIVING WITH YOU? Dependents over the age of 18 who are listed on the previous year's tax return will be considered in the family size calculation and should be listed below.

Do you have a spouse and/or any dependents living in your home? ☐ NO ☐ YES – Fill in below

NAME (Fist, M.I., Last)	Date of Birth	Relationship to You	U.S. Citizen or US National?
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

3. HEALTH INSURANCE INFORMATION

Please answer the following questions for yourself, as well as everyone you listed above in section 2 and attach a copy of each person's insurance card, as applicable.

Do you or anyone in your household have Medicare? ☐Yes ☐No	If yes, what type? ☐ Part A ☐ Part B	Name of person(s) with Medicare Benefits: _____ _____ _____ _____ _____
Do you or anyone in your household have Medical Assistance/MN Care? ☐Yes ☐No	If Yes, name of person(s) with Medical Assistance/MN Care: _____ _____ _____ _____ _____	
Do you or anyone in your household have other health insurance? ☐Yes ☐No	If Yes, name of person(s) with other health insurance: Name: _____ Type of Insurance: _____ _____ _____ _____	
Please send a copy of the front & back of the insurance card listing each person that is covered by that insurance.		

****REQUIRED HEALTH INSURANCE DOCUMENTATION****

For uninsured applicants, a Medical Assistance application is required before eligibility can be determined.

If a patient identifies insurance coverage in this section, we will make sure that we have billed that insurance.

4. DO YOU OR YOUR SPOUSE, IF MARRIED, HAVE ANY OF THE FOLLOWING ACCOUNT TYPES OR ASSETS?

☐ Real Estate ☐ Vehicles ☐ Checking acct ☐ Savings acct ☐ Stocks/bonds ☐ HRA/HSA
☐ Retirement/Investment accts ☐ Certificate of Deposit ☐ Trusts ☐ Money Market accounts
☐ No Assets

For each item checked above, please provide the requested information below.

a. Type of Asset	b. Asset Owner's Name	c. Statement date from attached verification documents (MM/YY)	d. Name of Financial Institution
Vehicle: Mileage_____			
Vehicle: Mileage_____			

****REQUIRED ASSET VERIFICATION DOCUMENTS****

Provide a clear photocopy (do not send originals, they will not be returned) of your most recent statement(s) verifying the balance/value of each asset listed above. Each statement should clearly identify you as the owner of the asset.

5. EMPLOYMENT INCOME

5a. ARE YOU EMPLOYED? ☐ No ☐ Yes – Fill in Below

5b. IF MARRIED, IS YOUR SPOUSE EMPLOYED? ☐ No ☐ Yes – Fill in Below ☐ Not Applicable

c. Employed worker's name	**d.** Employer's name	**e.** Hourly wage or annual salary	**f.** Hours worked per week	**g.** Tips / Bonuses
		$		
		$		
		$		

**** REQUIRED EMPLOYMENT INCOME VERIFICATION DOCUMENTS****

Provide a copy of your previous year's federal income tax form 1040. If your employment has changed, provide a copy of your 2 most recent paycheck stubs from each employer.

6. SELF-EMPLOYED INCOME

6a. ARE YOU SELF-EMPLOYED? ☐ No ☐ Yes – Fill in Below

6b. IF MARRIED, IS YOUR SPOUSE SELF-EMPLOYED? ☐ No ☐ Yes – Fill in Below ☐ Not Applicable

c. Self-employed worker's name	**d.** Business Name	**e.** Start Date	**f.** Yearly Income (Line 12 from your 1040 form)
			$
			$

**** REQUIRED SELF EMPLOYMENT VERIFICATION DOCUMENTS****

Provide a copy of your previous year's Federal Income Tax Form 1040 including all schedules.

7. DO YOU OR YOUR SPOUSE, IF MARRIED, RECEIVE INCOME FROM A SOURCE OTHER THAN WORK, INCLUDING THOSE LISTED BELOW:

- Social Security
- Supplemental Security Income (SSI)
- Public Assistance
- Spousal Support
- Worker's Compensation
- Trusts
- Unemployment
- Rental Income
- Veterans Benefits
- Interest
- Dividends
- Survivor Benefits
- Child Support
- Retirement/Pension
- Any other income or assistance from outside the household

☐No ☐Yes - Fill in Below

AMOUNTS LISTED IN COLUMN d. BELOW MUST MATCH SUPPORTING DOCUMENTATION *EXACTLY*

a. Income recipient's name	**b.** Type of income	**c.** Start date	**d.** Amount	**e.** How often received
			$	
			$	
			$	

****REQUIRED VERIFICATION DOCUMENTS FOR OTHER SOURCES OF INCOME****

- Social Security, SSI, Pension, Unemployment, Worker's Compensation, Public Assistance: Send your proof of benefits statement or award letter showing how much you receive each month.
- All other sources of income: Provide either (1) tax documents showing the income received, or (2) some other form of "official" documentation verifying the income and source.
- Non-cash benefits (such as food stamps and housing subsidies) do not count.
- Income is determined on a pre-tax basis (gross income).
- Provide a copy of your previous year's federal tax income form 1040 including all schedules.

8. IF QUESTIONS 5, 6, AND 7 ARE ANSWERED "NO" AND IF APPLICANT IS RECEIVING SUPPORT FROM ANOTHER INDIVIDUAL, STATEMENT OF FINANCIAL SUPPORT (ADDENDUM A), MUST BE COMPLETED AND SIGNED BY THE INDIVIDUAL PROVIDING SUPPORT.

9. IF YOU HAVE ADDITIONAL FACTORS THAT YOU WOULD LIKE US TO CONSIDER WITH YOUR APPLICATION, PLEASE LIST THEM HERE. USE AN ADDITIONAL PIECE OF PAPER IF NECESSARY.

10. BEFORE RETURNING THIS APPLICATION, MAKE SURE YOU HAVE ATTACHED ALL REQUIRED DOCUMENTATION AS OUTLINED ABOVE. IF MARRIED, Application must be signed and dated by applicant and spouse.

I acknowledge that the information on this application is true and correct to the best of my knowledge.	
DATE	PRIMARY APPLICANT'S SIGNATURE
DATE	SPOUSE'S SIGNATURE

PLEASE ALLOW 30 DAYS FOR PROCESSING. YOU WILL RECEIVE NOTIFICATION OF OUR DECISION BY MAIL.

Mail or drop off the completed application and the requested documentation to the office nearest you within 30 days of receiving the application:

Hutchinson Health Hospital 1095 Hwy 15 South Hutchinson, MN 55350 Phone: 320-484-4493 800-454-3903	Hutchinson Health Clinic 3 Century Avenue Hutchinson, MN 55350 Phone: 320-484-4493 800-454-3903	Hutchinson Health – Dassel Clinic 460 5th St. N. Dassel, MN 55325 Phone: 320-484-4493 800-454-3903

ADDENDUM A

Statement of Financial Support

Date_____
Name_____
Address_____

This is to confirm that I, _____, as
Name

the _____ of _____verify that I am
Relationship to applicant Applicant

providing full financial support for him/her at this time.

I acknowledge that the information provided on this form is true and correct to the best of my knowledge.

Signature: _____

Name (Please Print): _____

Date: _____

Hutchinson Health
Charity Care Application Instructions

I. Hutchinson Health Charity Care Application:

Applicants who meet the Charity Care income and asset guidelines and either have health insurance or are ineligible for MA or Minnesota Care are approved for Hutchinson Health Charity Care Program. Absent a change in individual circumstances, eligible patients shall continue to receive charity care for the period of one year following the earlier of the date the patient was determined to be an eligible patient or the date medically necessary services subject to charity care were first provided. Individuals may reapply for charity care in subsequent years. Hutchinson Health may request that an eligible patient reapply for charity care at any time if Hutchinson Health has reason to believe the individual's circumstances have changed. Every case will be decided on its own merits and the information will be kept confidential. Legal action may be initiated in cases against individuals obtaining charity care based on false or incomplete information.

II. Assistance with Application:

If you are unsure of what documentation to include or if you need any assistance with this application, please contact us as follows:

- By phone - call 320-484-4493 or 800-454-3903 to reach a Patient Financial Advocate.
- In person – present application to a Patient Financial Advocate at Hutchinson Health, 1095 Highway 15 South, Hutchinson, MN 55350. (Please stop at the main entrance desk or any registration desk for directions to the Patient Financial Advocate offices.)

III. Detailed Application Instructions: Charity Care applications must be completed in full by the applicant and returned with all necessary supporting documentation. All 'Yes / No' questions must be answered by checking the appropriate box, with each 'Yes' answer elaborated on as indicated on the application form.

Section 1: Primary Applicant – Should include applicant's name, date of birth, sex, marital status, address, citizenship,, social security number (optional), home phone number, and alternate phone number.

Section 2: Others living with You –

A. Applicants must identify their spouse, if married, as well as any dependents living with them, regardless of the need for dependent coverage through the Hutchinson Health Charity Care program. They should also indicate the citizenship and immigration status of all dependents.

B. Families claiming an adult child as a dependent must include a copy of their previous year's 1040 Federal Income Tax form, listing that child as a dependent in order for that child to be included when determining household size.

C. All applicants over the age of 18 must complete their own Hutchinson Health charity care application, regardless of dependent status. If a dependent is claimed on someone else's tax return all income and assets for the household must be verified.
- If the parents sign the financial support form AND the child over 18 was included in the household size (verified by 1040 tax form) the child is eligible under the parents' application
- If child over 18 applies and states they have no income AND the parent does not sign a financial support form, the child over 18 must submit a written document signed and dated of how they are supporting themselves.

D. If approved, Charity Care will cover the primary applicant, their spouse (if married) and any children who are under the age of 18 at the time of their approval.

E. Non-married Couples Residing Together:
- Without Children – Non-married couples residing together without children must file separately for Hutchinson Health's Charity Care program based on their individual income.
- With Children – Non-married couples residing together with children must file a single application for the household and will be considered for Hutchinson Health's Charity Care based on the combined household income.

F. Adding Dependents to an Existing Charity Care application:
- Adding a Spouse – a new application listing the spouse and all verifications must be submitted.
- Adding a Child Under the Age of 18 – In the event that a parent fails to list a child on their Charity Care application, or in the event that a child is born after Charity Care is approved, that child can be covered under the approved parent's Charity Care application.

Section 3: Health Insurance Information – Applicants must answer each of the questions in this section. For uninsured applicants, a Medical Assistance application is required before eligibility can be determined. If a patient identifies insurance coverage in this section, we will make sure that we have billed that insurance

A. Uninsured applicants must provide current and valid determinations from the appropriate Minnesota Health Care Programs (MHCP) for which they appear to be eligible.

B. Applicants who are denied for Medical Assistance and/or Minnesota Care must provide a valid denial for each uninsured family member, stating why they do not qualify. Valid denials include, but are not limited to: over income guidelines and over asset guidelines. Invalid denials include, but are not limited to: failure to complete application process, failure to complete renewal forms, failure to provide requested information, providing fraudulent information to MHCP.

C. Applications containing invalid MHCP denials, or those that do not include a determination as required and explained above, will be treated as incomplete applications

D. Applicants who currently have either Medicare or other medical insurance through an employer or through an individual policy do not need to provide MHCP determination

Section 4: Assets – Applicants must provide the following information for all Checking Accounts, Savings Accounts, vehicles, property other than your primary residence, HRA/HSA, Retirement/Investment Accounts (IRAs, 401Ks, Life Insurance, etc.), Stocks, Bonds, Certificates of Deposit, and/or Money Market Accounts: Name of the asset owner, type of asset, name of the financial institution, and the most recent statement date. Trusts or assets designated as a Trust will be reviewed on a case by case basis due to the varied nature of such assets. Applicants should include a copy of the Trust for review.

Section 5: Employment Income – Applicants must answer the question regarding their employment status and their spouse's employment status, and provide the employer's name, hourly wage or annual salary, hours worked per week, and any tips or bonuses earned.

A. Acceptable proof of employment income documentation:

- **Income Tax Form-** A copy of the previous year's 1040 Federal Income Tax form. (Tax form must represent the year prior to that in which the patient signed their application.) When using 1040 Federal Income Tax Forms for verification of income, the total income (line 22 on 1040, line 15 on 1040A) will be used as the annual household income. Any untaxed income will also be added to this total.
- **Paycheck Stubs -** Submit copies of applicant's two most recent check stubs for each job they, and/or their spouse hold. When using paycheck stubs for verification of current income, the gross income from each paycheck stub will be added together to obtain an estimated monthly income. Year-To-Date figures relative to check date may also be taken into consideration when evaluating income based on paycheck stubs.
- **Seasonal Employment-**Applicants with seasonal employment (including jobs based around the school-year) and applicants with commission based income must provide a copy of their previous year's 1040 Federal Income Tax Form.

Section 6: Self-Employment Income – Applicants must answer the question regarding their, or their spouse's, self-employment status, and provide the name of their business, the date they started their business, and the personal annual income they receive from their business, as indicated on their previous year's Federal Income Tax Form 1040, which must be included with the application as verification. Tax form must represent the year prior to that in which the patient signed their application.

Section 7: Other Income – Applicants must answer the question regarding sources of income they may have in addition to those they may have listed in sections 5 and 6, and provide the following information for each: Type of income, date they began receiving the income, the amount of income and the frequency of payment. The following documentation is required to support the other income:

A. Applicants collecting Social Security Income

- Copy of a current SSI Proof of Benefits statement.
- Copy of most recent bank account statement showing SSI direct deposit. Deposit line item must be clearly identifiable.

B. Retired applicants with income from a Pension or Retirement Plan

- Copy of monthly benefit statement OR
- Copy of most recent bank account statement showing direct deposit labeled with the agency providing payment.

C. Applicants collecting Long-Term or Short-Term Disability, Workers Compensation, or Unemployment

- Copy of monthly benefit statement OR
- Copy of most recent bank account statement showing direct deposit labeled with the agency providing payment.

D. Applicants collecting alimony and/or child support

- Copy of Divorce decree outlining amount of alimony or child support to be paid OR
- Copy of most recent bank account statement clearly showing payment deposited accompanied by a signed and dated explanation of how often payment is received and what payment is for (alimony or child support).

Section 8: Households with No Income – Applicants who answer 'No' in response to Sections 5, 6, and 7 must provide a completed "Statement of Financial Support" (Addendum A), indicating how they pay for their living expenses with no income.

- The form should be signed and dated by the person(s) providing the applicant with food, shelter, and/or financial support OR
- The applicant must provide a written statement, signed and dated by the applicant, clearly explaining how they are supporting themselves without an income.
- Full Time Students over 18 and supported by their parents must have the form completed by their parents, including signature and date.

Section 9: Additional Factors – Use the space indicated to list additional factors you would like us to consider with your application.

Section 10: Signature – The application must be signed and dated by the applicant. If the applicant is married, the application must also be signed by their spouse.

IV. Situations Not Covered Above:

As there is no way to account for every possible situation an applicant may find themselves in, be it related to employment/income, insurance coverage availability, housing/support, or anything else not covered above; Hutchinson Health reserves the right to make exceptions to the policy based on extenuating situations and may request additional information to support the extenuating circumstance.

V. Application Status:

A Patient Financial Advocate will review all incoming applications as soon as received.

A. Incomplete Applications:

If the application is incomplete, a letter will be sent to the applicant within three days of receipt of the application explaining what additional information/documentation is required to process the application. A guarantor account note will be entered in the billing system indicating what information/documentation is being requested.

B. Complete Applications:

Complete applications will be reviewed by a Patient Financial Advocate to determine preliminary approval or denial based on Hutchinson Health's Charity Care Policy. The determination will be reviewed with the Patient Financial Services Manager for final approval. Applicants who are approved for Hutchinson Health's Charity Care program will be notified in writing within 5 business days of the determination.

C. Denied Applications:

Applicants who submit a complete application but whose income and/or assets are above Hutchinson Health's Charity Care Income and Asset Guidelines will be sent a denial letter by mail within 5 business days of the determination indicating why the application was denied.

D. Renewal of Hutchinson Health Charity Care:

Approved financial assistance applications are valid for one year. Any applicant wanting to renew their financial assistance status must complete the entire application process again and have it approved.