William Newton Hospital

Rural Health Clinics

Cedar Vale • Dexter • Moline • Sedan • Health Professionals of Winfield

www.wnhcares.org

Financial Assistance Summary

In order to promote the health and well-being of the community served, individuals with limited financial resources who are unable to access entitlement programs shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon 120 to 200% Federal Poverty guidelines www.aspe.hhs.gov/poverty and will be revised annually in conjunction with the published updates by the United States Department of Health and Human Services.

Emergency Medical Care Policy

William Newton Hospital Rural Health Clinics provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay. When appropriate a transfer to another facility better equipped to administer the treatment will be arranged even if you cannot pay or do not have medical insurance. The necessity for medical treatment of 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.

Financial Assistance Application Process

Financial applications are located at the front desk and hospital website www.wnhcares.org. In order to receive a financial application by mail, contact the business office. The application must be filled out in its entirety with required documentation included. **Failure to submit the requested information may result in denial of the application because the financial eligibility could not be determined. Services rendered prior to the financial assistance approval period are the responsibility of the patient subject to payment policy guidelines, including prior accounts residing with agencies or law firms. You must contact these agencies or law firms directly.**

Eligibility

To be eligible for a 100% reduction from the patient portion of billed charges, the family/ household income must be at or below 120% of the current Federal Poverty Guidelines www.aspe.hhs.gov/poverty. If you fall between 120 to 200% of the Federal Poverty Guidelines an adjustment will be applied decreasing your gross charges. If a determination leaves the patient with a self-pay balance, payment terms will be established from the payment policy.

- Private pay account can be eligible for (1) Amount Generally Billed adjustment and (2) Financial Assistance adjustment.
- Insurance account can be eligible for (1) Insurance Contractual adjustment. (2) Financial Assistance adjustment on balance after insurance.

Payment Policy

Equal monthly payments on account balances are expected within the following time frames:

$1.00 to $300	60 days
$301 to $600	3 months
$601 to $1,500	6 months
$1,501 to $4,000	9 months
$4,001 up	12 months

We accept cash, check, money order and Visa, MasterCard or Discover.

Please return the application as soon as possible, but not later than 10 days to the clinic business office. You will receive a written notification of approval or denial generally within 30-90 days.

Clinic accounts prior to this application are still your responsibility.

Clinic financial assistance does not apply to bills received from your radiologist, anesthesia or ambulance. You must contact these providers directly.

Financial Assistance Application

Please return the application as soon as possible, but not later than 10 days. Please fill out the application in its entirety and supply required documents needed to process correctly. Failure to submit the requested information may result in denial of your application because your financial eligibility could not be determined. If there is any reason the listed documentation cannot be provided, please include a written explanation stating the reason. Allow the necessary time to verify the information that you have provided.

Patient(s) Legal Name: _____

If under 18 Guarantor Name: _____

Patient(s) Date of Birth: _____

Date of Service: _____

Account Number(s): _____ _____

Mailing Address: _____

Phone Number: _____

a. List members of Family Unit: (defined as applicant, spouse, and all legal dependents allowed by the Federal Government)

Name & Date of Birth	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

b. Are the children listed under the age of 18? Do you claim them on your tax return?

c. Are any members of your family unable to work due to age, illness or injury?

d. What members of the family are employed? If not employed, date last worked ___/____/____ and name of previous employer?

e. Are there any other medical or financial problems within the household?

f. Has the patient/guarantor filed for bankruptcy recently?

MONTHLY INCOME: **Provide all income verification listed below that applies to your Family Unit (applicant/patient, spouse/significant other and legal dependents. Include with your application proof of all income for (1) current complete month**: i.e. pay stubs, social security, disability, pension, unemployment, alimony, child support, etc.

A. Patient/Guarantor + $_____
B. Spouse + $_____
C. Other income from legal dependents + $_____
D. Other income + $_____

FAMILY **GROSS MONTHLY** INCOME = $_____**A**

MONTHLY EXPENSES: Please indicate your current average monthly expenses. It is not necessary to provide copies of these expenses, this is just an average.

E. Food + $_____
F. Utilities (gas, electric, water) + $_____
G. Auto, gas + $_____
H. Landline & Cell phone + $_____
I. Child Care + $_____
J. Other + $_____

TOTAL **MONTHLY** EXPENSES = $_____**B**

CREDITORS: Please indicate all current monthly payments**. Include with your application ALL receipts and/or bills you have listed.**

K. Rent/Mortgage + $_____
L. Insurance (auto) + $_____
M. Insurance (other) + $_____
N. Other payment + $_____
O. Other payment + $_____

TOTAL **MONTHLY** PAYMENTS = $_____**C**

ASSETS:

P. Bank Accounts
- Savings account + $_____
- Checking account + $_____

Q. Stocks, Bonds (market value) + $_____
R. IRA's/Retirement Funds + $_____
S. Life Insurance (cash value) + $_____

T. Real Estate

Attach another sheet if more than one property is owned.

- Mortgage loan balance + $_____

U. Trust + $_____

V. Vehicles + $_____

TOTAL ASSETS: = $_____

TOTAL MONTHLY FAMILY INCOME: $_____A

TOTAL MONTHLY EXPENSES: _ $_____B + C

MARGINAL DISPOSABLE INCOME: = $_____

The following documents are REQUIRED to be turned in with your application:

- **Current Bank Statement (1)**
- **Proof of income for (1) current complete month: i.e. pay stubs, social security, disability, pension, unemployment, alimony, child support etc.**
- **Federal Income Tax Return (not just W-2)**

Clinic financial assistance does not apply to bills received from your doctor, radiologist, anesthesia or ambulance. You must contact these providers directly. Clinic accounts prior to this application are still your responsibility.

I understand that the information which I submit is subject to verification by William Newton Hospital Rural Health Clinic and subject to review by others required. I certify the information in this financial application is true and correct. I also understand that if any portion of the information I have provided is determined to be falsified, I will be responsible for all medical expenses incurred at William Newton Hospital Rural Health Clinic. I agree to promptly notify William Newton Hospital Rural Health Clinic of any changes in financial status affecting my ability to pay. I understand this application is good for 30 days.

Signature: _____ Date: _____

Signature of Spouse: _____ Date: _____
(If married, spouse signature required)