CROZER HEALTH

Hospital Statement

Crozer Health System Financial Assistance Policy

Plain Language Summary

Crozer Health System (CHS) Financial Assistance Policy/Program (FAP) exists to provide eligible patients, partially or fully-discounted emergency or other medically necessary healthcare services provided by CHS and a substantially related entity (as defined by the IRS), are hereinafter referred to as CHS. Patients seeking Financial Assistance must apply for the program, which is summarized herein.

Eligible Services - Emergency or other medically necessary healthcare services provided by CHS and billed by CHS. The FAP only applies to services billed by CHS. Other services which are separately billed by other providers, such as physicians or laboratories, are not eligible under the FAP.

Eligible Patients - Patients receiving eligible services, who submit a complete Financial Assistance Application (including related documentation/information), and who are determined eligible for Financial Assistance by CHS

How to Apply – FAP and related Application Form may be obtained/completed/submitted as follows:

- In person at any CHS hospital patient access departments or Emergency Room desk.
- Request documents be mailed to you, by calling CHS Financial Resource Center at 610-447-2336
- Request documents by mail/or visiting in-person: CHS Financial Resource Center located at One Medical Center Blvd Upland PA 19013. Visiting In-person, Enter through the Out Patient Entrance (Park in the Upland Garage) upon entering through the outpatient entrance walk straight to the Financial Resource Center located in the first room on your right. (The CHS Financial Assistance Policy is also available upon request by mail, or in person, at this location.)
- Download the documents from the CHS website: https://www.crozerhealth.org/patients-visitors/policies/financial-assistance-policy/
- Mail completed applications (with all documentation/information specified in the application instructions) to: CHS Attn: Financial Resource Center. One Medical Center Blvd. Upland PA 19013; or deliver in person to CHS Financial Resource Center, One Medical Center Blvd. Upland PA 19013. This office is located inside the Outpatient Entrance (park in the Upland garage) upon entering the outpatient entrance walk straight to the Financial Resource Center located in the first room on your right. Please call 610-447-2336 for further directions.

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 400% of the Federal Government's Federal Poverty Guidelines (FPG). Eligibility for Financial Assistance means that Eligible Persons will have their care covered fully or partially, and they will not be billed more than "Amounts Generally Billed" (AGB) to insured persons (AGB, as defined in IRC Section 501(r) by the Internal Revenue Service). Financial Assistance levels, based solely on Family Income and FPG, are:

- Family Income at 0 to 200% of FPG - Full Financial Assistance; $0 is billable to the patient.
- Family Income above 200% to 400% of FPG - Partial Financial Assistance; AGB is maximum billable to the patient.

Note: Other criteria beyond FPG are also considered (i.e., availability of cash or other assets that may be converted to cash, and excess monthly net income relative to monthly household expenditures), which may result in exceptions to the preceding. If no Family Income is reported, information will be required as to how daily needs are met. CHS financial counselors review submitted applications which are complete, and determines Financial Assistance Eligibility in accordance with CHS Financial Assistance Policy. Incomplete applications are not considered, but applicants are notified and given an opportunity to furnish the missing documentation/information.

CHS also translates its FAP, FAP application form and the plain language summary of its FAP in other languages wherein the primary language of the residents of the community served CHS represents 5 percent or 1,000; whichever

is less; of the population of individuals likely to be affected or encountered by CHS. Translated versions available upon request in person at the address below; and on the CHS website

https://www.crozerhealth.org/patients-visitors/policies/financial-assistance-policy/

For help, assistance or questions please visit or call: CHS Financial Resource Center located at one Medical Center Blvd. Upland PA 19013 Visiting In-person, park in the Upland Garage and enter through the outpatient entrance walk straight to the first room on your right. If you need further directions or have questions please call the financial resource center at 610-447-2336 Monday through Friday from 8:30 AM to 5:00 PM.

Crozer Health System
Financial Assistance Program Application

Crozer- Health System (CHS) offers financial assistance for medically necessary care provided to eligible individuals and families. Your financial needs will determine a reduction or elimination of your financial obligation.

You may qualify for CHS's Financial Assistance Program if you:

- Have limited or no health insurance;
- Are not eligible for government assistance such as Medicaid; and
- Cooperate in providing necessary information to support your financial needs.

The process to apply for Financial Assistance is as follows:

- Complete the CHS Financial Assistance Program ("Application");
- In order to determine eligibility, CHS will need proof of your income and household size (We use Federal Poverty Guidelines to determine financial need);
- You will need to assist CHS determine if there are payment options through insurance such as Worker's Compensation, Auto, Liability, Medicaid, Insurance Exchange or COBRA, CHIPS ect.;
- Provide the documentation listed on checklist (if applicable);
- This program will be applied only to medically necessary and emergent health care services provided by Crozer- Health System; and
- After you complete the Application, CHS will notify in writing by mail to inform you if you qualify for the Financial Assistance Program.

You may be required to complete a Medical Assistance application at any time during the process.

Failure to cooperate in the Medical Assistance application process may make you ineligible for CHS Financial Assistance Program.

If you have any questions regarding this Application please contact:

Crozer Health System Financial Assistance Hotline at 610-447-2336
Hours of operation: Monday through Friday 8:00 am to 4:00 pm EST.

For more information about our Health System, please visit us at: www.crozerhealth.org

CROZER HEALTH

Hospital Statement

FINANCIAL ASSISTANCE FEE SCHEDULE IS BASED ON FEDERAL POVERTY GUIDELINE

Patient Name: _____

Account #: _____ (if known)

Patient Date of Birth: _____

___ Crozer Chester Medical Center

___ Taylor Hospital

___ Springfield Hospital

____Community Hospital

_____Delaware County Memorial Hospital

Insured Name		Social Security	Date of Birth		
Street Address		City	State and Zip		
Employer		Home Phone	Cell Phone		
Monthly Family Income		Family Assets	Family Members (immediate family living in the household)		
			Name	Relationship	Date of Birth
Salary/Wages $	Unemployment $	Savings Account/CDs $			
Soc Sec $	Work/Comp $	Checking Account $			
Pension $	Alimony $	Stocks, Bonds $			
Public Assistance	Other	Other Assets			

$	$	$			
Total Monthly Income $		Total Assets $	Total Number of Family Members (including applicant)		

I certify that the above information is true and accurate to the best of my knowledge. Furthermore, I will make application for any insurance coverage (Medicaid, Medicare, Insurance, etc.), which may be available for payment of my hospital charges, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. I understand that it is my obligation to provide the hospital with proof of determination for Medicaid, if requested. If hospital requests additional documentation and I do not provide it, I understand my application for financial assistance may be denied and I will be financially responsible for any bills incurred.

I understand that this application is made so that the hospital can judge my eligibility for financial assistance under CHS's Financial Assistance Policy,(see page 2 of Exhibit 2 for required documents needed to complete the financial assistance application) If any information I have given proves to be untrue, I understand that the hospital may reevaluate my financial status and take whatever action becomes appropriate.

_____ _____

Date of Request Applicant's Signature

APPLICATION FOR FINANCIAL ASSISTANCE Crozer Health System

All completed applications should be mailed to the following address:

Crozer Health System

Attn: Financial Resource Center

One Medical Center Blvd. Upland, PA 19013

610-447-2336

DO NOT WRITE BELOW THIS LINE (FOR OFFICE USE ONLY)

CROZER HEALTH

Hospital Statement

Eligibility Determination		
Date of Eligibility Determination	___Application Approved – Level 1 (S62) ___Application Approved – Level 2 (S64) ___Application Approved – Level 3 (S66) ___Application Auto Approved – Level 1 (S61)	___Application Denied – Over Income ___Application Denied – Patient Uncooperative ___Application Denied – Other (Residency, assets, etc.)

Financial Assistance Termination Date		Signature of Person Making Determination Date

Financial Assistance Program Application Checklist

1. **If you have income:**

    - ☐ Attach a copy of your most recent Federal Income Tax Return
      (1040, 1040A, 1040EZ If you filed taxes you must supply a copy of the return)

2. **If you did not file a federal tax return, you must:**

    - ☐ State in writing why you did no file a Federal Income Tax Return on a separate sheet of paper
    - ☐ Send us a copy of the most recent Federal Income Tax Return of anyone who claimed you as a dependent

3. **Attach additional proof of household income, if applicable:**

    - ☐ 1099 forms or award letters: Social Security, Pension/Retirement, Disability, etc….
    - ☐ Unemployment Notice of Final Determination or Workers Compensation
    - ☐ Pay stubs for the last three months
    - ☐ If you are self-employed, you must include a schedule C and/or statement of income and expenses

4. **If you have no income:**

    - ☐ A notarized letter of no income will be required
      (A CHS Notary can notarize a letter stating the patient or financially responsible individual has no income)

5. **Letter of Denial for Medical Assistance:**

    - ☐ Based on initial financial screening, you may need to apply for Medical Assistance and provide a copy of your Letter of Denial before CHS can approve your application

6. **Completed and signed Financial Assistance Program application:**

    - ☐ Make sure to complete and include **all information** that applies to you
    - ☐ Provide a photo ID ie. driver's license, passport, state ID
    - ☐ Provide additional documents Requested _____
    - ☐ _____