Public Benefit Assistance

You may be eligible for MEDICAID or other state or federal benefits that would pay for part or all of your hospital bill.

We have enlisted The Midland Group to explore what benefits may be available to you. The Midland Group is dedicated to assisting eligible uninsured patients to obtain health insurance through public benefits.

A representative from The Midland Group will contact you by phone or mail while you are in the hospital or after discharge to determine whether they can assist you in making an application of benefits. In order to determine your eligibility, The Midlands Group staff will need your assistance in gathering basic information.

If The Midland Group accepts your case, they will follow your case until your Medicaid application has been approved or denied. All of this will be done at no charge to you.

Patient authorized Cheyenne County Hospital to release general patient information to The Midland Group to contact patient to explore public benefits eligibility.

_____ _____

Patient Signature **Date**

Patient Name: _____ **(please print name)**

Financial Assistance Application Changes

Effective January 1, 2018, we have implemented the following changes to our Financial Assistance Policy:

- The application period for completion of a financial assistance application is available for a minimum of 240 days from the date Cheyenne County Hospital provides the patient with the first post discharge billing statement for patient services.
- Once the patient has qualified, they are eligible for 365 days (one year).
- Patients are eligible based on family size and household income. The household income must be less than 200% of the poverty level to receive 100% financial assistance.
- The Application process includes completion of a "Personal Financial Statement for Financial Assistance" and providing verification documents. Verifiable information may include, but is not limited to, the following:

    - Individual or family income (income tax return with copies of earnings statements – W-2 forms, 1099 forms, etc. for past 2 years)
    - Copies of most recent 90 days of payroll stubs, Social Security checks, or unemployment checks.
    - Copies of most recent 60 days of bank statements
    - Current trust fund statements
    - Mortgage statements
    - Annual property tax statements
    - In the absence of income, a letter of support from individuals providing for the patient's basic living needs
    - County tax appraisal statement
    - Documentation of employment status
    - Household family size
    - Credit history reports
    - Denial letter from Medicaid (all family members must apply for Medicaid – kids must apply individually)
    - Previous or current returns from collection agencies with documentation regarding inability to pay

If you have any questions about the Financial Assistance Policy, please feel free to contact our Financial Counselor, Marla Ross at (785) 332-2104.

OFFICE USE ONLY

Patient Pays _____ Valid Date _____

Guarantor # _____ Initials _____

Effective through _____

Cheyenne County Hospital
Financial Assistance Program
Information Form

(PLEASE PRINT)

NAME: _____ SSN#_____

Spouse

ADDRESS: _____ SSN#_____

_____ FAMILY SIZE: _____

NAMES OF ALL FAMILY MEMBERS: (currently living in the same household)

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Proof of income must be submitted in order to qualify for the Charity Care Program. Examples of proof would be: Tax returns from last year, Payroll stubs, W-2 forms. For households with 2 working adults, we must have both person's payroll stubs and/or W-2 forms if those were the proof of income used to qualify.

CHARITY CARE QUALIFIES ARE TO BE REVIEWED ON AN ANNUAL BASIS OR IF INCOME INFORMATION CHANGES FOR CONTINUED QUALIFICATION.

I understand the above information and believe it to be true and correct to the best of my knowledge. Anyone providing false information for qualification will be terminated from the Charity Care Program and will be subject to full charges retroactive to the prior months when false information was provided.

SIGNED _____ DATE: _____

Personal Financial Statement for Financial Assistance

Patient Name	Age	Phone Number	Marital Status S M W D	Social Security Number

Date Pt. Received:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $
Please Return By:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $
Date Returned:	Acct. # / Balance:	/ $	; Acct. # / Balance:	/ $

Patient		**Person Responsible for Bill (if not patient)**	**Relationship**
Street:		Name:	
		Street	
City, ST, Zip		City, ST Zip	
Phone: ( )	Cell: ( )	Phone: ( )	Cell: ( )

EMPLOYMENT

Patient's Employer:	Guarantor's Employer:
Occupation:	Occupation:
If unemployed, Name of Last Employer:	If unemployed, Name of Last Employer:
How Long Unemployed?	How Long Unemployed?

LIST BELOW ALL MEMBERS OF HOUSEHOLD BEGINNING WITH PATIENT

Name	Age	Relationship to Patient

Do you have health insurance coverage available? Yes _____ No _____

If yes, why not available for this date of service? _____

If no, please indicate the reason for lack of insurance coverage? Insurance cost too high? Yes_____ No_____;
Pre-existing condition? Yes_____ No_____; Other, please describe _____

Have you applied for Medicaid? Yes_____ No_____ Date Applied: _____

If denied, date: _____ Reason for Denial: _____

If denied, please attach a copy of the Medicaid denial letter.

MONTHLY INCOME: Attach Copies of Proof of Income			
	Patient	Spouse	Other Members of Household (18 and older)
Wages (Gross)	$	$	
Social Security			
Pensions			
Unemployment/Work Comp			
Alimony/Child Support			
Government Assistance			
Disability Payments			
Dividends/Interest			
Other, List			
MONTHLY INCOME SUBTOTAL			
TOTAL INCOME:	**MONTHLY: $**		**YEARLY: $**

EXPENSES	MONTHLY	BALANCE DUE
Mortgage or Rent Payment	$	$
Car Payment		
Utilities (Gas, Electric, Water		
Cable		
Phone (Including Cell)		
Food		
Child Care		
Clothing		
Insurance (Auto, Life, Health)		
Gas/Transportation		
Recreation		
Physicians		
Hospitals		
Other Medical		
Credit Cards		
Other Expenses (Describe)		
TOTAL EXPENSES:	$	$

HOUSEHOLD ASSETS	VALUE
Savings	$
Checking	
Stocks and Bonds	
Mutual Funds, Money Marekt, etc.	
Cash Value of Life Insurance	
Real Estate Value	
Farming Real Estate Value	
Vehicles Value (not primary)	
Jewelry & Other Personal Property	
Other Assets (Describe)	
TOTAL HOUSEHOLD ASSETS:	$

HOUSEHOLD DEBTS	VALUE
Home Loan	$
Auto Loan	
Credit Card Debt	
Other: Total Expenses from "Balance Due"	
column - (Mortgage + Car Loan + Cr, Cards)	
TOTAL HOUSEHOLD DEBTS:	$

OTHER PERTINENT INFORMATION REGARDING FINANCIAL SITUATION

I VERIFY THE INFORMATION PROVIDED IS CORRECT AND COMPLETE. I AUTHORIZE VERIFICATION OF ANY INFORMATION AND UNDERSTAND THAT ADDITIONAL DOCUMENTATION MAY BE REQUESTED. IF ANY INFORMATION IS FOUND TO BE FALSE, FINANCIAL ARRANGEMENT OR ASSISTANCE MAY BE VOIDED.

Patient/Responsible Party Signature Date:

Application Determination: Approved / Denied Date Determination Letter Mailed: _____

Reason for Denial: _____

Hospital Representative Signature(s) Date: