MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL ASSISTANCE PROGRAM

Before completing the form, have you applied for Financial Assistance at another Munson Healthcare facility within the last 12 months? If so, you may not need to complete this application.

Under its assistance program Munson Healthcare Otsego Memorial Hospital will make available a reasonable amount of uncompensated or reduced-price services to persons eligible under applicable guidelines. Munson Healthcare Otsego Memorial Hospital Assistance Program services are not limited to any specific hospital service. Individual eligibility for assistance is determined by measuring family income in relation to family size against the income poverty level established by the Community Service Administration. The current income requirements for assistance are listed below:

MHC FINANCIAL ASSISTANCE INCOME GUIDE			
Household Size	**200% FPL**	**300% FPL**	**400% FPL**
	100% FINANCIAL ASSISTANCE	**75% FINANCIAL ASSISTANCE**	**65% FINANCIAL ASSISTANCE**
	Annual	**Annual**	**Annual**
1	$25,520.00	$38,280.00	$51,040.00
2	$34,480.00	$51,720.00	$68,960.00
3	$43,440.00	$65,160.00	$86,880.00
4	$52,400.00	$78,600.00	$104,800.00
5	$61,360.00	$92,040.00	$122,720.00
6	$70,320.00	$105,480.00	$140,640.00
7	$79,280.00	$118,920.00	$158,560.00
8	$88,240.00	$132,360.00	$176,480.00
Each Add'l Person, Add	$8,960.00	$13,440.00	$17,920.00

If you think you may be eligible for assistance, you should return the enclosed form with all required documentation or contact the Business Office during normal business hours, Monday thru Friday between the hours of 8:00 a.m. and 4:00 p.m.

- **Hospital bills last name starts with A-L: 989-731-2200**
- **Hospital bills last name starts with M-Z: 989-731-6228**
- **Physician bills: 989-731-7774**

A determination will be made within 30 days receipt if all pertinent information is returned with the application. The following documents are required:

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Complete Federal Tax Return & Schedules**
***All W-2's (Federal)**
***Four (4) most recent pay stubs.**

Munson Healthcare Otsego Memorial Hospital
Financial Assistance Application

Deadline for receipt of Financial Assistance Application for services – The later of: 30 days after the date written notice of financial assistance is provided, or 240 days after the first post-discharge billing statement for previous care. Application and requested documentation must be returned within 14 calendar days.

I. RESPONSIBLE PARTY						**SSN** ________________
LAST NAME	FIRST NAME		MI	MARITAL STATUS		DATE OF BIRTH
STREET ADDRESS				PO BOX		
CITY	STATE	ZIP		HOW LONG AT THIS ADDRESS?		HOME PHONE
ARE YOU EMPLOYED? ____ YES ____NO		____FULL-TIME		____PART-TIME		____SEASONAL
EMPLOYER NAME AND ADDRESS						YEARS EMPLOYED _______
DO YOU FILE TAXES? _____ YES _____ NO	ARE YOU *RECEIVING* OR HAVE YOU *APPLIED* FOR SOCIAL **SECURITY DISABILITY** PAYMENTS?					

II. SPOUSE OR SIGNIFICANT OTHER				**SSN** ________________
NAME				DATE OF BIRTH
ARE YOU EMPLOYED? ____ YES ____NO	____FULL-TIME		____PART-TIME	____SEASONAL
EMPLOYER'S NAME AND ADDRESS				YEARS EMPLOYED ______
DO YOU FILE TAXES _____ YES _____NO	ARE YOU *RECEIVING* OR HAVE YOU *APPLIED* FOR SOCIAL **SECURITY DISABILITY** PAYMENTS?			

III. HOUSEHOLD INFORMATION (ALL OTHER PERSONS IN HOUSEHOLD)		
NAME	DOB	RELATIONSHIP
TOTAL PERSONS IN HOUSEHOLD:		

IV. MONTHLY INCOME		
RESPONSIBLE PARTY'S MONTHLY INCOME		$
SPOUSE/SIGNIFICANT OTHER'S MONTHLY INCOME	+	$
TOTAL MONTHLY INCOME:	**=**	**$**

V. HAVE YOU BEEN APPROVED FOR MEDICAID?	Yes ________________ NO______________
FILL IN SPENDDOWN AMOUNT IF APPLICABLE	APPROVED SPENDDOWN AMOUNT _________________

VI. MISCELLANEOUS INCOME PER MONTH – complete All fields with gross monthly amount or N/A if not applicable			
DIVIDENDS, INTEREST	$	PENSIONS	$
SOCIAL SECURITY	$	INVESTMENT/RENTAL INCOME	$
UNEMPLOYMENT/WORKER'S COMPENSATION	$	GRANTS	$
CHILD SUPPORT/ALIMONY	$	Other	$
TOTAL MONTHLY MISCELLANEOUS INCOME:	$		
MONTHLY INCOME:	+		$
TOTAL MONTHLY INCOME:	= $	**ANNUAL:**	**$**

ALL INCOMPLETE OR FRAUDULENT APPLICATIONS WILL BE DENIED AND FOLLOW THE PROCEDURE GUIDELINES DEFINED IN THE FINANCIAL ASSISTANCE POLICY

YOU ARE REQUIRED TO NOTIFY MUNSON OMH OF ANY INCOME CHANGES DURING YOUR APPROVAL PERIOD

IN COMPLETING THIS FINANCIAL STATEMENT, I HEREBY AFFIRM THAT THE ABOVE STATEMENTS ARE CORRECT AND COMPLETE, AND I GIVE MY CONSENT TO FURTHER VERIFICATION BY MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL OR ITS AGENTS.

SIGNATURE/ DATE: ____________________________________/__________________

RELATIONSHIP IF OTHER THAN PATIENT: ____________________

FOR OFFICE USE ONLY			
APPROVED/DENIED	%	$	DATE:
APPROVED BY:			

Approved applications will be effective for services covered according to Financial Assistance Policy guidelines for up to one (1) year from the approval date.

The following documents are required (if applicable):

***SSA 1099 (Social Security proof)**
***Pension Proof**
***Unemployment Proof**
***Child Support/Spousal Support**
***Complete Federal Tax Return & Schedules**
***All W-2's (Federal)**
***Four (4) most recent pay stubs.**

MUNSON HEALTHCARE OTSEGO MEMORIAL HOSPITAL ASSISTANCE PROGRAM
Financial Assistance Policy – Plain Language Summary

Munson Healthcare's Financial Assistance Policy (FAP), exists to provide eligible patients partial or fully discounted emergent or medically necessary care. Patients who will be seeking Financial Assistance must apply for the program, which is summarized below.

Eligible Services – Emergent and/or medically necessary healthcare services provided by MHOMH and MHOMH Medical Group providers. The services only include services billed by MHOMH or MHOMH Medical Group. Other services, such as Pathology, physicians not employed by MHOMH and radiology interpretations provided by an organization other than Munson Healthcare, are not eligible under the FAP.

Eligible Patients – Patients receiving Eligible Services, who submit a completed Financial Assistance Application including all required documentation/information, and who are determined to be eligible for Financial Assistance according to the policy guidelines.

How to Apply – Financial Assistance Applications (including Plain Language and full Financial Assistance Policy) may be obtained /completed/submitted as follows:

- Obtain an application at the hospital Information Desk or at the front desk of any Hospital owned clinic.
- Request an application be mailed to you, by calling 989-731-7777 for Physician or 989-731-2198 for Hospital Billing.
- Request an application by visiting in person: MHOMH Administrative Services Building, 271 W. McCoy Rd., Gaylord, MI 49735.
- Download an application from the MHOMH website at: www.myOMH.org/patient-assistance-program
- Mail Completed applications (with all required documentation/information specified in the application instructions) to MHOMH Financial Assistance, 271 W. McCoy Rd., Gaylord, MI 49735. Specify hospital assistance of physician assistance.

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 Level (FPL). Eligibility for Financial Assistance means that Eligible persons will have their care fully covered or partially, and they will not be billed more than "Amounts Generally Billed" (AGB) to insured persons (AGB, as defined by IRS Section 501(r)). Financial Assistance levels based solely on Family income and FPL are:

FPL	0 to 200	201 to 300%	301% to 400%
Discount %	100%	75%	65%

Note: Other criteria beyond the FPL are also considered, including: The availability of other program coverage for the services; management discretion.

The following documents are required if applicable:

**SSA 1099 (Social Security proof)*
**Pension Proof*
**Unemployment Proof*
**Child Support/Spousal Support*
** Complete Federal Tax Return & Schedules; W-2's*
**Four (4) most recent pay stubs.*

A determination will be made within 30 days receipt if all pertinent information is returned with the application.

For questions or help: Call Hospital Billing during normal business hours, Monday thru Friday between the hours of 8:00 a.m. and 4:00 p.m. at 989-731-2200 or 800-322-3664 ext. 2200 if your last name starts with A-L, or 989-731-6228 or 800-322-3664 ext. 6228 if your last name starts with M-Z; for Physician Billing call 989-731-7777.