Boca Raton Regional Hospital

Financial Assistance Program

Application Package

Boca Raton Regional Hospital

Financial Assistance Program Application Guide

This guide will walk prospective, current or previous patients of Boca Raton Regional Hospital through the steps, forms and documentation that are required to apply for the Boca Raton Regional Hospital (BRRH) *Financial Assistance Program*. The program provides for a partial or complete write-off of the patient account balance of **uninsured and underinsured patients** provided the patient meets the criteria of the program. Eligibility for the program is available for the current calendar year, unless specified otherwise under special circumstances.
** Please note that this program only involves the charges and associated billings of all emergent procedures and those procedures deemed medically necessary that are performed at Boca Raton Regional Hospital. Please refer to Attachment A of the Financial Assistance Policy for covered and non-covered physicians. Additionally, this policy does not apply to procedures classified as Plastic Surgery (cosmetic procedures).

Eligibility for the BRRH *Financial Assistance Program* is based on financial need at the time of application by assessing the patient's ability to pay using household income and assets. **Households with sufficient income and/or assets are expected to meet their financial responsibility for services provided by BRRH.**

The BRRH *Financial Assistance Program* is only available to residents of Palm Beach County, Florida. Applicants who reside outside of Palm Beach County, Florida may qualify for Emergency services only, including any inpatient stay resulting from that Emergency Visit.

The following steps must be completed in order to ensure that we can properly determine your eligibility for the program.

Step-1: Patient must:

- Be evaluated by Med Assist (contracted vendor hired to evaluate patients for state and local assistance) for Medicaid eligibility. Patients will need to provide information about their income, citizenship, residence, assets and dependents. Med Assist can be reached at (561) 955-3662.
- **Or** apply or have applied to Medicaid and receive(d) written verification of approval or denial. Patients may apply for Medicaid assistance for up to 3-months from the date of service. [To complete an application or receive information contact Florida Medicaid at (561) 616-5255 or http://www.fdhc.state.fl.us/Medicaid]. If approval is obtained, than the patient is not eligible for BRRH

Financial Assistance Program benefits. If Medicaid eligibility is denied then proceed to **Step-2**.

Step-2: Patient must:

- Be evaluated by Med Assist (contracted vendor hired to evaluate patients for state and local assistance) for Healthcare District of Palm Beach County eligibility. Patients will need to provide information about their income, citizenship, residence, assets and dependents. Med Assist can be reached at (561) 955-3662.
- **Or** apply or have applied to Healthcare District of Palm Beach County (HCDPBC) or similar State or County assistance program and receive(d) written verification of approval or denial. Patients may apply for assistance for up to 120-days from the date of service. [To complete an application or receive information contact HCDPBC at (866) 930-0035 or http://www.hcdpbc.org/]. If approval is obtained, than the patient is not eligible for BRRH *Financial Assistance Program* benefits. If eligibility is denied than proceed to **Step-3**.

Step-3: Complete the application (Form-A) and sign it. If you do not fill out the application completely or present fraudulent information, your application will be sent back to you and you may not receive approval for the BRRH Financial Assistance Program.

- **Assessment of responsibility to pay: If after reviewing the individuals income, expenses and assets (per Form-A) it is deemed that there are "sufficient" resources available to cover the hospitals charges the application request will be denied. This applies even if the applicant meets criteria under the Poverty Level Guidelines.**

Step-4: Gather and copy the following documentation. By providing as much information as possible you will enable BRRH to better assess your eligibility for the program. A written **Notarized** explanation must be provided for all missing documents and failure to provide all of the requested information may result in a delay or denial of your application

1) Written verification of approval or denial from Medicaid, Healthcare District of Palm Beach County, or a similar State or County assistance program [Questions regarding these programs should be directed to (561) 955-3662]. In lieu of a formal denial, documentation by Med Assist of a screening interview and lack of eligibility will be sufficient.
2) Income tax returns (copy of Form 1040) for the past 2 years or a written statement documenting reasons why a tax return was not filed. If you did not file tax returns, then we need your two most recent W-2 forms, along with a signed Form-B (included in this packet).
3) Two most recent pay stubs from your employer

4) Documentation of unemployment or worker's compensation benefits (if applicable)
5) Copy of valid photo identification (for applicants over the age of 17)
6) Mortgage payment or Lease payment documentation
7) Utility and water bills
8) Telephone bill/cable bill
9) Other medical bills
10) Bank statements for the past 2-months
11) Vehicle Registration and loan information (if applicable)
12) Any other living expenses you have that would assist us in determining your monthly expenses

Step-5: Complete Form-C (BRRH *Financial Assistance Program* – Income Attestation)

Step-6: When you have completed forms A, B and C and gathered all the required documentation please make copies and send to:

Boca Raton Regional Hospital
Attn: Patient Financial Services – Financial Assistance Program
626 Meadows Road
Boca Raton, FL 33486

After receiving the patient's application and any financial information or other documentation needed to determine eligibility, a hospital representative will notify the patient, in writing, of their eligibility determination. The hospital will also advise the patient of his or her responsibilities under the programs guidelines.

If you have any further questions, please call Patient Financial Services at (888) 629-7686.

Thank you for choosing Boca Raton Regional Hospital.

Program Eligibility Requirements:

Type of Financial Assistance	Eligibility	Discount and Amount Due
Non Catastrophic **100% (1)**	Meets all other applications criteria and: Family household income total **is < or = to 200% of the FPG** in effect at the time of the most recent service	**Discount:** 100% write-off of Qualifying Dollars
Non Catastrophic **50% (1)**	Meets all other applications criteria and: Family household income total **ranges from 201% and 300% of the FPG** in effect at the time of the most recent service	**Discount:** 50% write-off of Qualifying Dollar
Catastrophic Approval **75%**	Amount owed by the patient for BRRH **medical Bills exceeds patient's family household annual income by 25% or greater AND the patient earned between 300% and 600% of FPG** in effect at the time of the most recent service **Note: FAP Application Required**	**Discount:** 75% write-off of Qualifying Dollars

FORM-A **BRRH** *FINANCIAL ASSISTANCE PROGRAM APPLICATION*

Name of Applicant:		Applicant's SS#_____ Spouse/Other's SS# _____
Name of Spouse/Other:	Home Phone #:	Marital Status:_____ Date of Birth: Applicant _____ Spouse/Other_____
Address:		Work Phone #: Applicant _____ Spouse/Other _____

Do you have children? Y or N If yes, please list ages? _____

Optional: You do not have to answer, but it may aid in qualifying you for a federal or state assistance program such as Medicaid or Disability.

Are you pregnant? Y or N Are you disabled? Y or N

PART-1: PLANNED EXPENSES and PAYMENTS

A - CASH EXPENSES	*MONTHLY*	*NEXT 12 MO.*	*TOTAL BAL. DUE*
FOOD			
CLOTHING			
MEDICAL			
PERSONAL			
HOUSEHOLD:			
House Payments(Mortgage) / Rent			
Fuel			
Electricity			
Telephone			
Cable TV			
Water and/or Sewer			
Other			
HOME REPAIR and MAINTENANCE:			
EDUCATION: (Tuition, Books, Fees, etc.)			
GIFTS: (Holidays, Birthdays, Charity, Church, etc.)			
RECREATION			
VEHICLES:			
Payment 1: Year Make Model Loan #			
Payment 2: Year Make Model Loan #			
Gas & Oil			

Insurance			
Maintenance & Repair			
TRANSPORTATION: (Bus, Taxi, Train, etc.)			
INSURANCE:			
Health			
Dental			
Life			
Other			
TAXES PAYABLE: (taxes you pay in for the month/year)			
Income			
Social Security			
Other			
CHILD CARE			
CHILD SUPPORT / ALIMONY (PAID OUT)			
PLANNED CASH PURCHASES			
OTHER:			
A. TOTAL CASH EXPENSES			
B - DEBT PAYMENTS			
OTHER VEHICLES and EQUIPMENT			
OTHER: (Credit cards, Installment loans, Personal debts, etc.)			
List:			
B. TOTAL DEBT PAYMENTS			
PART-1 TOTAL: (A + B)			

PART-2: HOUSEHOLD INCOME

APPLICANT (Wages, Tips, Overtime, etc.) **EMPLOYER** _____			
SPOUSE/OTHER (Wages, Tips, Overtime, etc.) **EMPLOYER** _____			
BUSINESS INCOME:			
OTHER (Social Security, Retirement, Alimony, Child support, VA, Welfare, Investment/Other income, etc.) **LIST**:			

PART-2 TOTAL:				

PART-3: ASSETS

CHECKING ACCOUNT: **Bank**:	**Address:**	**Acct #:**	Balance:
SAVINGS ACCOUNT: **Bank:**	**Address:**	**Acct #:**	Balance:
OTHER ACCOUNTS: **Bank:**	**Address:**	**Acct #:**	Balance:
CDs, STOCK's, BOND's:		**Acct #:**	Balance:
PRINCIPAL RESIDENCE:	**Value:**		----------
OTHER ASSETS: (Other Real Estate, Machinery, etc.)			Value:
PART-3 TOTAL:			

PART-4: SUMMARY

A. TOTAL INCOME (PART-2 TOTAL)			
B. CASH (PART-3 TOTAL)			
C. TOTAL EXPENSES AND DEBT PAYMENTS (PART-1 TOTAL)			
D. *BALANCE (A + B – C)*			

I attest that all the information I have provided above is correct.

Signature of patient or responsible party: _____

Date: _____

FORM-B

STATEMENT OF "NO FILE" FOR FEDERAL INCOME TAXES

I, _____(please print name) hereby state that I have not filed federal income tax forms with the Internal Revenue Service of the USA in the past two years due to a low-income status. I understand that my signing this form gives Boca Raton Regional Hospital the right to verify this information and deny me eligibility for the BRRH Financial Assistance Program if the information is fraudulent.

Signature of patient or responsible party: _____

Date: _____

FORM-C

BRRH *Financial Assistance Program* - Income Attestation

I_____ certify that my family income for the past twelve months has been $_____ and there are _____ people in my family. My current income can be verified by contacting: _____ at phone: _____.

I understand that in accordance with Florida Statutes 817.50, providing false information to defraud a hospital for the purposes of obtaining goods and or services, is a misdemeanor in the second degree.

Signature of patient or responsible party: _____

Date: _____

FLORIDA LAW PROVIDES:

1) **"It is a misdemeanor of the second degree (FS817.50) to fraudulently obtain services from the hospital by giving a false or fictitious name, a false or fictitious address, any other false or fictitious information required to be obtained by the hospital in compliance with FS-382.31, et seq., or shall assign to the hospital the proceeds of any insurance contract, then knowing that such contract is no longer in force or is invalid, or is void for any reason, any such shall be prima facie evidence of the intent of such person to defraud such hospital."**

2) This is only an application to obtain Financial Assistance and **not** an agreement to give free services.

3) The acceptance of your application is at the option of the hospital and requires the consent of the medical staff, your physician, the availability of beds in the hospital, and certain budgetary constraints.

4) This application, at the hospital's option, may be granted in whole or in part.

5) All free care allowances, at the option, may be reinstated by the hospital, as per the following terms:

   a) If there is any omission or mistake in the application for Financial Assistance;

   b) If hospital charges are the result of an injury and there is a claim, lawsuit or litigation between the patient, their insurance company or a third party, entire charges are the responsibility of the patient. The patient will be ineligible for benefits under the Financial Assistance Program and the Self-Pay Discount will not be applicable.

   c) If the patient, or person responsible for payment of the hospital bill expires and leaves a probate estate, even if the only asset is a claim or legal action that accrues to the estate.