Attachment I

Re: Application for Assistance

Thank you for expressing an interest in our Financial Assistance Program. Depending on your family income and family size, you may be eligible for a discount up to 100% of the amount owed on your hospital bill. In order for us to determine if you qualify for a discount, or to determine a monthly payment plan if you do not qualify for a full discount, please complete the enclosed ***Application for Assistance*** and provide the following information:

- Most current pay stub(s) showing year-to-date earnings for all working members of the household.
- Most recent bank statement(s).
- Support for all other income including, but not limited to, SSI or other government income, retirement, child support, alimony, food stamps.
- Most recent income tax return IF self-employed or clergy.

If you do not have any income, please provide an explanation as to how you support yourself and your family.

Failure to provide complete information may result in delay or denial of your application.

Please return your completed application and the information above in the enclosed return envelope within 30 days of the date of this letter.

You will be notified of the determination of eligibility within 30 days of receipt of your application.

A copy of the hospital's financial assistance policy can be obtained from the hospital's website www.oaklawnhospital.org or by calling the Patient Accounts Service Center and requesting a copy be mailed to you.

If you have any questions concerning completion of the application or the required information, please do not hesitate to contact us. The Patient Accounts Service Center can be reached by calling 269-789-7000 or 269-789-7181. Our hours are Monday through Thursday from 8:00am to 5:00pm and Friday 8:00am to 4:00pm.

Sincerely,

Oaklawn Hospital
Patient Accounts Service Center

APPLICATION FOR ASSISTANCE/MONTHLY PAYMENT PLAN

Date _____

Patient Name _____

Patient Adress _____

Best telephone number(s) to reach you: _____

Best time of day to reach you: _____

List the names of all patients this application applies to: _____

_____

Please provide information below for all individuals living in the household (including your spouse or significant other) AND all persons you or your spouse are financially responsible for (continue on back of form if needed).

Name	Relationship	Age	Claim on income tax return Y/N
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total number of dependents claimed on the responsible party's income tax return _____

Other than the responsible party listed above, is there anyone else financially responsible for or required to carry health insurance for the patient? If yes, please provide their name, address, and telephone number on the back of this form. Yes _____ No_____

Responsible Party Employment Information

Employer _____

Address _____

Occupation _____ Health Insurance offered Y/N_____

How long employed _____ Hours/week _____ Gross pay/week _____

Spouse or Other Household Employment Information

Employer _____

Address _____

Occupation _____ Health Insurance offered Y/N_____

How long employed _____ Hours/week _____ Gross pay/week _____

Include income for all working members of household. Use back of form if necessary.

Other Source(s) of Income

Other sources of income include, but are not limited to**, unemployment benefits, social security payments, investment income, rental income, child support, food stamps, or any other income received.**

Source _____ Monthly Amount $_____

Source _____ Monthly Amount $_____

Source _____ Monthly Amount $_____

Indicate on the back of this form any additional information you feel will be helpful to us in determining your eligibility for assistance or a payment plan.

Authorization (Your signature is required before we will process your application)

I do hereby believe this to be a true and complete representation of my income and financial situation as of the date indicated below. I understand that the Hospital may be requesting a credit report to verify the above information.

Signature of Responsible Party _____ Date _____

If you need help completing this form or if you have any questions, please contact the Patient Accounts Service Center by calling 269-789-7000 or 269-789-7181. Office hours are Monday through Thursday, 8:00am to 5:00pm and Friday 8:00am to 4:00pm.

Reviewed 9/2023

Attachment II

Family Size	2023 Poverty Level Annual Income	170% of PL: Full Write-Off If At or Below	200% of PL: 75% Write-Off If At or Below	250% of PL: 75% Write-off If At or Below
1	$14,580	$25,515	$29,160	$ 36,450
2	19,720	34,510	39,440	49,300
3	24,860	43,505	49,720	62,150
4	30,000	52,500	60,000	75,000
5	35,140	61,495	70,280	87,850
6	40,280	70,490	80,560	100,700
7	45,420	79,485	90,840	113,550
8	50,560	88,480	101,120	126,400

For families larger than 8 members, add $5,140 times the FPL factor above.

Effective 02/01/2023 the AGB (Amounts Generally Billed) is:

Inpatient: 28.68%
Outpatient: 22.32%

Eligibility for 50/50:

Income is less than…	Balance is at least …
175% of PL	$2,000
176% to 250% of PL	$3,000
251% to 300% of PL	$4,000
301% to 350% of PL	$6,000
351% to 400% of PL	$8,000
401 % to 450% of PL	$10,000
451% to 500% of PL	$12,000
501% to 550% of PL	$15,000
551% to 600% of PL	$18,000
More than 600% of PL	$22,000

Reviewed 9/2023