Wyoming Medical Center
WHMG Wyoming Medical Health Group

Financial Assistance Policy/Procedure

Wyoming Medical Center prides itself in being a responsible member of this community. Our commitment to improving the health of our community means ensuring that everyone has access to quality medical care. Our Financial Assistance Program is available to assist with the financial needs of those who have limited ability to pay for emergent and medically necessary services.

Upon the request of the patient, it is the policy of Wyoming Medical Center to consider a financial assistance adjustment if it has been determined that all other avenues have been exhausted, the balance of the account(s) is equal to or greater than $300.00, and the patient states they have no other means of making payment on the account. Financial Assistance adjustments are granted at the discretion of Wyoming Medical Center upon consideration of the following guidelines:

Financial Assistance adjustments are available to an eligible person requiring emergent and medically necessary treatment, but who is determined by Wyoming Medical Center to be unable to pay for hospital services. Eligibility for financial assistance shall be extended to a person whose family income is 200% or less than the most current year's Federal Poverty guidelines. A person whose income is greater than 200% of the most current year's Federal Poverty guidelines, but 275% or less of the guidelines may be eligible for a partial adjustment on billed charges.

If an applicant is deemed eligible for financial assistance they will not be charged more than amounts generally billed (AGB) to individuals with insurance covering that same care. The AGB is calculated annually based on actual commercial claim reimbursement data.

Federal Poverty Level Guidelines for 2016

Family Size	Federal Poverty Guidelines (FPG)	0% through 200% of FPG	201% through 225% of FPG	226% through 250% of FPG	251% through 275% of FPG	Greater than 275% of FPG
		100% Adjustment	75% Adjustment	50% Adjustment	25% Adjustment	0% Adjustment on Income Alone
1	$11,880	$23,760	$26,730	$29,700	$32,670	$35,640
2	$16,020	$32,040	$36,045	$40,005	$44,055	$48,060
3	$20,160	$40,320	$45,360	$50,400	$55,440	$60,480
4	$24,300	$48,600	$54,675	$60,750	$66,825	$72,900
5	$28,440	$56,880	$63,990	$71,100	$78,210	$85,320
6	$32,580	$65,160	$73,305	$81,450	$89,595	$97,740
7	$36,730	$73,460	$82,643	$91,825	$101,008	$110,190
8	$40,890	$81,780	$92,003	$102,225	$112,448	$122,670

*For family units of more than 8 members, add $4,160 per additional member.

A financial assistance adjustment may be considered only after a careful review of the patient's accounts and a determination has been made that there is no means of their own available. A Financial Assistance Application (Attachment #1) may be completed in person with the assistance of Patient Financial Services, or it may be sent by mail. Patient Financial Services may also qualify applicants through a presumptive method. Such as but not limited to applicants who are receiving care from a homeless clinic, living in designated low income housing, food stamps or participating in Women, Infants and Children programs.

The patient will be given 21 days from the time the application is received to ensure the information is returned in a timely manner. The applicant must complete the application thoroughly and provide any and all information requested that pertain to his/her situation. In the event the application is not returned in 21 days, is incomplete or contains false information, the applicant will automatically be denied.

Application for assistance under this program must be made within 60 days of the date the final bill is sent to the patient. In certain circumstances, this requirement may be waived at the discretion of WMC Patient Financial Services Management.

An applicant may only apply to this program once on any account unless they encounter a catastrophic situation. A catastrophic situation is defined as one or more of the following:

> The applicant and/or spouse is unable to work within the foreseeable future due to a medical condition as verified by a physician and income levels have decreased by 50 percent as verified by tax returns and/or pay stubs. Applicants must be out of work a minimum of 90 days.
>
> The applicant and/or spouse has developed a terminal illness as verified by a physician and income levels have decreased by 50 percent as verified by tax returns and/or pay subs.
>
> The applicant and/or spouse has died and income levels have decreased by 50 percent as verified tax returns and/or pay stubs.

The Financial Assistance Application shall be completed in full, including the patient's name, address, telephone number, occupation, employer, and names of spouse and legal dependents. Legal dependents shall be identified as such, based on whether or not they are claimed as dependents on the most recent income tax return. Also included shall be the family income for the most recent month, as well as the last twelve months. The income reported must include all wage earners in the household. Patients who are claimed as dependents on another individual's income tax returns must report income of the other individual(s) as well as their own. Verification of earnings must be provided by submitting requested forms, which may include some or all of the following: income tax returns, pay stubs, unemployment compensation forms, or letters from employers. If the patient indicates that no income has been earned, a copy of a letter from the Social Security Department or the unemployment compensation may be requested. Also, we will request a copy of the letter, verifying that benefits under Public Assistance Programs, including Medicare and Medicaid, are denied. If the patient has not yet applied for Public Aid, he or she is expected to do so. If the patient returns the application without sufficient proof of income, or if other information has not been provided, he or she shall be contacted by telephone or mail within 48 hours of receipt of the application. Approval may be denied for failure to complete an application.

Wyoming Medical Center recognizes the fact that there may be instances in which a patient's income exceeds the previously mentioned guidelines, but the patient's expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burdens. A financial assistance adjustment may also be approved for these individuals.

Upon review of the Financial Assistance Application, Patient Financial Services will request the completion of a financial questionnaire (Attachment #2). The same income information outlined previously shall be included for the entire household. Expense information should also be documented, including copies of any bills, loans, leases, and mortgage payments available. Upon completion of the questionnaire, eligibility will be determined by comparing total income and the total expenses.

Allowable Liabilities:

- Utilities qualify as liability if not included in the rent. The applicant must verify actual utility costs and no more than $500.00 per month will be used.

- Transportation costs subject to a $500 per month limitation, which includes the cost of auto loans, auto insurance, maintenance and license fees
- Child Support
- Medical debts other than those owed to WMC
- Day Care
- Health Insurance
- Prescriptions
- Alimony
- Court judgments on necessities such as Medical debt, child support and IRS liens.
- Student Loans to which current payments are being made.

Upon completion of one or both of the above-mentioned applications/questionnaires, Patient Financial Services will determine eligibility. Patient Financial Services will notify the patient of the outcome within 48 business hours.

If the patient receives a partial adjustment, the amount owed by the patient shall be indicated in the appropriate location on the determination letter from Patient Financial Services. Also, indicated on the form shall be 100% approvals or denials. In cases of partial adjustments or denials, the patient will be responsible for payment arrangements within 30 days from the date the signed form is sent to the patient. Thereafter, routine collection procedures shall be followed in good faith before extreme collection efforts are made. In the case of a partial adjustment the applicant will only be responsible for the Amount Generally Billed (AGB).

The patient may appeal the denial of their application to the Wyoming Medical Center Financial Assistance Committee once at the regular quarterly meeting of the committee. Such request for appeal must be submitted to the Manager or Director of Patient Financial Services in writing within thirty (30) days from the date of determination who will forward the request to the committee for hearing at the next regularly scheduled meeting. The determination of the appeal by the committee will be final and notice of the final determination will be made to the applicant by mail. Denials for applications received outside the stated time limits, submitting a false application or due to any other restriction of the policy may not be appealed.

Excluded Applicants:

- Illegal Aliens

Financial Assistance applications are valid for 180 days from date of determination.

Confindetial Financial Assistance Questionnaire

Wyoming Medical Center

Patient Name_____

Account Numbers_____ **Return By**_____

Applicant's Full Name	Date of Birth	Social Security Number	No. in Household
Co. Applicant's Full Name	Date of Birth	Social Security Number	No. in Household
Mailing Address	City	State, Zip	Telephone/Cell No.
Employer	Position	No. of Years	Gross Wages per Month
Employer's Street Address	City	State, Zip	Telephone No.
Co-Applicant Employer	Position	No. of Years	Gross Wages per Month
Other Sources of Income (Including Pensions. Food Stamps, Child Support, etc.)	Amount per Month		
Assets	**Amount**	**Liabilities**	**Amount**
Cash			
Investments (Describe)			
Home (Current Value)		Home Mortgage/Rent	
Other Real Estate			
Automobiles (Year/Make/Model)	Amount Owed	Monthly Payment Amount	
Automobiles continued	Amount Owed	Monthly Payment Amount	
Other (Describe)		Other Debt (Describe)	

Please attach a copy of your most recent federal tax return, or letter of non-filing from the IRS, and pay stubs, social security, unemployment or workers compensation letter. You may be required to apply for Medicaid assistance before your request for financial assistance can be approved.

I certify that the information in this application is true and complete. In the event I receive financial assistance from Wyoming Medical Center, I will keep it completely confidential. If I breach this confidentiality I understand that it may result in restoration of full charges.

Signature of Applicant_____ Date_____

Signature of Co-Applicant_____ Date_____

If you need further assistance please call _____ at _____

***This application is used for Wyoming Medical Center, Wyoming Medical Health Group, Advantage Orthopedics and Neurosurgery and Casper Surgical Center.

***Separate providers are under no obligation to honor or accept the outcome of this application.

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