NORTHSIDE HOSPITAL

# PHYSICIAN PRACTICE FINANCIAL ASSISTANCE PROGRAM POLICY

Northside Hospital, Inc. and its tax-exempt affiliates ("Northside") are committed to fulfilling their charitable mission as a not-for-profit health care provider. Uninsured, underinsured and medically indigent patients having limited or inadequate resources to pay for health care services rendered at a Northside Physician Practice office may be eligible for full or partial financial assistance through Northside's Physician Practice Financial Assistance Program.

Financial assistance may be available for medically necessary health care services provided to persons who meet Northside's Physician Practice Financial Assistance Program criteria. Medically necessary services are services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms which, if otherwise left untreated, would pose a threat to the patient's ongoing health or well-being. Each request for financial assistance will be reviewed independently and allowances may be made for extenuating circumstances on a case-by-case basis.

Northside will offer financial assistance adjustments to patients who meet the established Physician Practice Financial Assistance Program guidelines and have completed the Physician Practice Financial Assistance Application.

Northside uses a sliding scale to determine a patient's eligibility for financial assistance. Specifically, patients with annual household incomes below 125 percent of the Federal Poverty Income Level may qualify to receive free care. Patients with annual incomes between 126 and 250 percent of the Federal Poverty Income Level may receive discounted care depending on the sliding scale and whether they meet Northside's Physician Practice Financial Assistance Program guidelines. Income and household size will be evaluated for financial assistance approval. Patients who are insured or have a third party liability claim are only eligible to apply for financial assistance in the event they have a remaining balance after all payment resources are exhausted. Additionally, Northside may make adjustments for medically indigent patients whose medical or hospital bills from all related and unrelated health care providers, after payment by all third-party sources, would cause the Patient significant financial hardship.

To be considered for a discount under the Physician Practice Financial Assistance Program, a patient must complete Northside's Physician Practice Financial Assistance Application and provide Northside with financial and other information needed to determine eligibility. Patients may be asked to provide:

- Tax Return (typically IRS form 1040)
- Social Security benefit documentation
- Disability benefit documentation
- State recognition of low income level
- Proof of household size

After receiving a patient's application for financial assistance and supporting financial information or other documentation needed to determine eligibility for assistance, Northside will provide written notification regarding the determination within thirty (30) to sixty (60) days of receiving the request. If a patient's application is incomplete, Northside will contact the patient to collect any outstanding information needed to complete the application and upon receipt of the missing information, Northside will determine whether the patient qualifies for financial assistance.

Financial assistance approvals will continue to be valid for six (6) months, unless a change in the patient's circumstances voids his/her eligibility. All charges incurred at the initial visit that prompted the patient to apply for financial assistance, as well as all charges incurred at subsequent visits occurring prior to the final financial assistance award determination, will be adjusted in accordance with the determination. Adjustments will not, however, be made to charges incurred for specimens or blood samples processed by outside third party vendors such as laboratories (e.g., Quest, LabCorp, Solstas).

Northside may request information to confirm that a patient's financial circumstances continue to meet the Physician Practice Financial Assistance Program guidelines.

*Please note that Northside will treat all applications, supporting documentation and communications with the highest regard for patient confidentiality. Patients will be asked to manually redact their SSN on any copy of supporting documentation. If personnel receive copies of supporting documentation that contains patients' SSN, they will need to black out the SSN.*

If you have any questions about the Physician Practice Financial Assistance Program contact Felecia Baisden at the Northside Hospital Business Office at (404) 851-8021. Additionally, completed Physician Practice Financial Assistance Applications should be submitted by mail to:

Northside Hospital Business Office
1100 Johnson Ferry Road, Suite 780
Atlanta, Georgia 30342
Attention: Financial Assistance

For all other questions regarding your account and/or financial assistance generally, contact one of Northside's Financial Counseling Offices between the hours of 9:00am and 4:00pm, Monday through Friday:

- Atlanta Financial Counseling Office – (404) 851-8878
- Forsyth Financial Counseling Office – (770) 844-3246
- Cherokee Financial Counseling Office – (770) 720-5484

Patients who are granted financial assistance should notify Galen Advisors (Physician Practice Billing Department) at (678) 223-7932 to receive a billing adjustment for all services provided. Because you may receive bills from Galen while your Physician Practice Financial Assistance Application is pending, it is important that you notify Galen as soon as possible once you are awarded financial assistance.

**Northside Hospital Physician Practice Financial Assistance Program**

**Application Form**

| Patient Name | Phone | Address |
|---|---|---|
| | | |
| DOB | Date of Service | Physician Practice Code: WM8<br>Treating Physician: Dr. Kothapally Dr. McGinn Dr. Patil |

Thank you for choosing a Northside Hospital Physician Practice. This application is used to determine your eligibility for free or discounted services based on family income level. If your income is at or below 250% of the federal poverty level (as defined below), you may be eligible to receive specified services at no cost or at a discount. Submission of this application, however, is not a guarantee of no cost or discounted services; additionally, submission of this application does not guarantee financial assistance for services provided outside of your physician's practice (*i.e.* , services provided in the hospital setting, or laboratory, diagnostic and radiological tests provided outside of your physician's office).

If you have any questions about the Physician Practice Financial Assistance Program please contact the Northside Hospital Business Office at (404) 851 -6500 select option "0" followed by option "2" for the Financial Assistance Dept. Additionally, completed Physician Practice Financial Assistance Applications should be submitted by mail to:

Northside Hospital Business Office
1001 Summit Blvs NE Suite 150
Atlanta, Georgia 30319
Attention: Financial Assistance

Applications can also be faxed to: 404-845-1778

**Please note: If you have been approved to receive Financial Assistance from Northside Hospital at any time during the previous six (6) months, please contact Physician Billing Serices (PBS) at (678) 223-7932 before completing and submitting this application, as you may still be eligible to receive Financial Assistance under your previous award.**

| Family Size | Federal Poverty Level (125%) | Federal Poverty Level (250%) |
|---|---|---|
| 1 | $16,100 | $32,200 |
| 2 | $21,775 | $43,550 |
| 3 | $27,450 | $54,900 |
| 4 | $33,125 | $66,250 |
| 5 | $38,800 | $77,600 |
| 6 | $44,475 | $88,950 |
| 7 | $50,150 | $100,300 |
| 8 | $55,825 | $111,650 |

| Discount Level | Eligibility | Service Discount |
|---|---|---|
| Indigent Care | Gross Income at or below 125% of the Federal Poverty Level | 100% off of Gross Charges* |
| Charity Care | Gross Income Between 126% and 250% of the Federal Poverty Level | 80% off of Gross Charges* |

** Gross Charges are the full, established prices for medical care that are consistently and uniformly charged to all patients before applying any contractual allowances, discounts or deductions.*

Please review the following steps, gather the requested information and return this application and all supporting documentation to the address above.

**1. Compile Proof of Income Documentation.**

Income includes, but is not limited to, the sum of your wages, salaries, public assistance, unemployment, retirement, social security and alimony. Acceptable examples of proof of income documentation include:

- Tax Return (typically IRS form 1040)**
- Social Security benefit documentation
- Disability benefit documentation
- State recognition of low income level

***Please note that a W-2 is not a tax return and does not qualify as sufficient proof of income.*

****PLEASE BLACKEN OUT YOUR SOCIAL SECURITY NUMBER ON ANY FORMS SUBMITTED.**

**2. Compile Proof of Household Size Documentation.**

"Household" is defined to include related family members such as a spouse and children, as well as all unrelated dependents who rely on the patient for financial support. To claim family members on this application, you must be able to prove support (*i.e* ., tax return showing dependents); otherwise your income will be based on a family size of one.

**3. List Total Income and Family Size.**

Total Annual Household Income _____

Total Family Size _____

**4. Submit and return the completed application and all supplemental documents by mail to address above . Upon review of this information, Northside Hospital will determine whether you are eligible for financial assistance.**

**5. Indicate whether you have previously been approved for Financial Assistance in conjunction with services received at a Northside Hospital Practice or a Northside Hospital Facility, and if so, the month/year of this decision.**

YES _____ NO _____ Approval Date _____

**By signing below, I acknowledge that all information provided in support of the this application is accurate and that I understand the requirements and parameters of the Northside Hospital Physician Practice Financial Assistance Program.**

***Patient Signature*** ***Date***

**FOR INTERNAL USE ONLY:**

Submit application with supporting documentation to the Northside Hospital Business Office.

Submission Date:

Approved Services ❑ 100% Indigent Care Discount ❑ 80% Charity Care Discount