



NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE

VIRGINIA INDIGENT HEALTH CARE TRUST

AUGUSTA HEALTH CARE COMMUNITY ASSISTANCE

To meet the continuing needs of its service community, Augusta Health Care, Inc. has formulated a financial assistance program to assist its patients in resolving hospital accounts. This policy applies to all services normally covered by third party payers (insurances). Included services are hospital, home health, durable medical equipment, hospice, and physician offices associated with Augusta Health Care, Inc. **This policy does not cover convenience items, drugs from the pharmacy, or physician offices over which AHC has no control.**

To be considered eligible for financial assistance, your **household** income must be at or below the following levels (effective April 1, 2009):

| FAMILY SIZE | FEDERAL POVERTY GUIDELINE 12-MONTH INCOME |
|------------------------------------------------------------|--------------------------------------------------|
| 1 | \$10,830 |
| 2 | 14,570 |
| 3 | 18,310 |
| 4 | 22,050 |
| 5 | 25,790 |
| 6 | 29,530 |
| 7 | 33,270 |
| 8 | 37,010 |
| More than 8, add \$3,740 for each additional member | |

SLIDING SCALE FEE REDUCTION SCHEDULE

| FAMILY INCOME RELATIVE TO FEDERAL POVERTY GUIDELINES | REDUCTION OF FEES |
|-------------------------------------------------------------|--------------------------|
| 0 to 150 percent of Federal Guidelines | 100% |
| 151 to 175 percent of Federal Guidelines | 75% |
| 176 to 200 percent of Federal Guidelines | 50% |
| 201 to 225 percent of Federal Guidelines | 25% |
| 226 to 250 percent of Federal Guidelines | 10% |

Dependent upon the family income level, the charges will be reduced or eliminated. You may be responsible for a portion of your bill, even though you have been approved. **Approvals are effective for a period of six months.**

NOTE: It is the patient's responsibility to notify AMC of any services received in that six-month period.

As a further condition of eligibility **you must make application for any assistance** (Medicare, Medicaid, SLH, medical insurance, auto insurance, etc.) that may be available for payment of your hospital charge. You must take any action reasonably necessary to obtain such assistance and assign or pay to the hospital the amount recovered for hospital charges. **There are no exceptions to this rule.** If your charges are pending legal action by your attorney, or are considered to be workers compensation claims, they are not eligible for financial assistance. **Accounts, referred to outside agencies for collection, or those pending legal action, will not be considered eligible for financial assistance.**

If you think you may be eligible for financial assistance, you may complete the form (on back of this sheet), and submit it to the Business Office of Augusta Medical Center.

Augusta Health Care, Inc. will make a written determination of your eligibility for FINANCIAL ASSISTANCE within 20 working days of your application.

Complete the back of this sheet and mail application to: **AUGUSTA MEDICAL CENTER
ATTENTION: BUSINESS OFFICE (FAF)
POST OFFICE BOX 1000
FISHERSVILLE, VA 22939**



AUGUSTA MEDICAL CENTER

APPLICATION FOR FINANCIAL ASSISTANCE

Virginia Indigent Health Care Trust Augusta Health Care Community Assistance

Household Members

Family Size _____. Include Self, Spouse, and dependent children under age 21, living in the home.

Applicant's Full Name _____ Soc.Sec.# _____

Name of Spouse _____ Soc.Sec.# _____

Mailing Address _____

City _____ State _____ Zip _____ Phone _____

Dependent children under age 21, living in the home.

| Name | Age | How related to applicant | Social Security number |
|-------|-------|--------------------------|------------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Household Income

List all income, earned and unearned. (Use the 'before deductions' amount).

TOTAL income in last 3 months _____. Provide proof of this income. Failure to provide proof of income will delay the processing of your application.

Gross income listed on last federal income tax return _____. Provide copy of 1040 Form.

- NOTE:
1. You MUST attach proof of income as requested above.
 2. Augusta Health Care, Inc. reserves the right to request further income information.
 3. If you listed zero income: attach written explanation as to who provides your room and board.
 4. Social Security recipients, you must provide your gross Social Security amount (before Medicare deduction).

Approvals are for a period of six months from date of application.

CERTIFICATION

I certify that the above information is true and accurate to the best of my knowledge. Further, I will make application for any assistance (Medicaid, SLH, Medicare, Medical Insurance, Auto Insurance, etc.) that may be available for payment of my hospital charge, and I will take any action reasonably necessary to obtain such assistance and will assign or pay to the hospital the amount recovered for hospital charges. If any information I have given proves to be untrue, I understand that the hospital may re-evaluate my financial status and take whatever action becomes appropriate.

Date of Request _____ Applicant's Signature _____

OFFICE USE ONLY: Authorized by: _____