

Financial Assistance Policy

Plain Language Summary



Affiliated with  SENTARA.

Policy Statement

It is the policy of Hospital for Extended Recovery to provide to all patients quality care regardless of the ability to pay. To achieve this end, the Hospital provides financial assistance to patients based on their income, family size, and needs. These programs include charity, assistance with Medicaid eligibility and discounted care. In addition, we may be able to help you arrange a manageable payment plan. It is important that you let us know if you will have trouble paying your bill. Federal and State laws require all hospitals to seek full payment of what they bill patients. This means we may have to turn unpaid bills over to a collection agency, which could affect your credit status.

Determination of Eligibility

Just as the Hospital is proactive in providing assistance, so shall its patients be proactive in providing the necessary information for establishing eligibility for financial assistance. As a not-for-profit organization, we must be able to justify our community commitment. Patients must follow through with the application process and requirements for assistance in order for a determination to be made regarding eligibility.

Eligibility is determined after the patient or designee submits a completed financial information statement along with verification of income (i.e. tax returns or two months of pay stubs). All efforts will be made to establish whether the patient is eligible for Financial Assistance before the patient leaves the Hospital, but we will accept applications up to 240 days after discharge. If a patient qualifies for financial assistance the entire balance of his/her account will be adjusted based on the household size/income as compared to the Federal Poverty Level Guidelines (FPG). The patient will be notified in writing of the hospital's determination of eligibility. Please refer to the full policy for complete details.

Income up to:	200% of FPG	300% of FPG	400% of FPG	500% of FPG	600% of FPG
Discount	100%	85%	70%	55%	40%

“Amounts Generally Billed” (AGB) are calculated by dividing the sum of all allowed claims for all private insurers and Medicare during the year by the gross charges for those claims and is based on the look back period of the hospital's most recently closed fiscal year. The AGB is represented by a percentage value and changes in July of each year. Patients that are determined to be eligible for Financial Assistance will qualify for discounts that reduce the account to below AGB; assuring the eligible patient will never be charged more than the AGB.

For information about the financial assistance process, to obtain copies of the complete Financial Assistance Policy including the application or for help applying for financial assistance please contact our financial counselor directly by phone, mail or on our website:

Hospital for Extended Recovery
600 Gresham Dr STE 700
Norfolk, VA 23507

757-388-1384

www.sentara.com/hospitalforextendedrecovery

This plain language summary, the entire financial assistance policy and the application are also available in Spanish by using the contact information above.

In some instances where a completed financial assistance application is unable to be obtained, information received from the transferring hospital that the patient is eligible for financial assistance will be used in lieu of the application.

HOSPITAL *for* EXTENDED RECOVERY

Financial Assistance Application

Hospital Account # _____

ADMIT

DISCHARGE

Patient / Responsible Party

Name

Address

City ST ZIP

Best Phone Number

Total Number of People in Household

Monthly Income Sources

\$

\$

\$

\$

Interest/Dividends \$

Total \$

List every member of the patient's household, including patient, as listed on the most recently filed tax return

Name	AGE / Relation	Employer	Gross Income
	/ Patient		
	/ Spouse		
	/		
	/		
	/		

(Please use additional sheets if necessary)

Bank Information

Please indicate [C]hecking or [S]avings

Bank Name	Account Type / Number	Account Balance

Please Attach Your Bank Statement(s)

Employment Information

___ Employed ___ Self Employed ___ Retired

* If Employed or Self-Employed, please provide 2 months pay stubs and/or most recently filed tax return

* If retired, please provide Social Security and/or pension benefit information

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOUR HOUSEHOLD

- | | |
|--|---|
| <input type="checkbox"/> Receive Veteran's Benefits | <input type="checkbox"/> Receive SNAP Benefits |
| <input type="checkbox"/> Receive Social Security | <input type="checkbox"/> Own Rental Property |
| <input type="checkbox"/> Use Public Health Clinics | <input type="checkbox"/> Have Stocks, Bonds, CD's etc |
| <input type="checkbox"/> Receive Unemployment Benefits | |

Do you own your home?

Rent?

Live with family/friends?

IMPORTANT:

We cannot process applications that are not complete. Therefore, if it is not complete, we will return it to you for completion. Thank you.

Before returning this application be sure to sign and date in the space provided

I certify that the above information is true and correct. I authorize Hospital for Extended Recovery to verify this information with employers or other agencies. I also understand that this information is subject to review by Federal and/or State agencies.

I also understand that I am expected to make application to any other help that may be available to me.

Applicant's Signature

Date

Refer to Policy3-012 for current federal income levels. Anything above minimum must be approved by CEO.

Date received at H.E.R.:

Received By:

Income Documents verified:

Income greater than max threshold

Yes No

Yes=potential discount

Income less than min threshold Yes No

Yes=Write off

Administrative Approval

Date