Model Fair Accessible Individual Rate (FAIR) Care Program for Hospitals

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Model FAIR Care Program for Hospitals

1. Purpose.

To establish the policy/procedures for the administration of FAIR Care by this hospital.

2. Definitions. Used in this article, the following terms have the following meanings:

2.1. **Allowable Medical Expenses** Family medical bills from any provider that if paid, would qualify as deductible medical expenses for federal income tax purposes.

2.2. **Annual Reduced Price Fee** The patient's liability to the Hospital for Reduced Price Care as provided for in Section 3(B) in this Program.

2.3. **Application** The FAIR Care application as attached in Appendix A. FAIR Care includes Charity Care, Reduced Price Care, and Medical Hardship Assistance. The Hospital shall translate the application into the five languages most frequently used by the Hospital's service area.

2.4. **Available Assets** The resources, as distinct from Family Income that are taken into account in determining eligibility for Medical Hardship Assistance. Available assets do not include: the residence in which a patient and/or the patient's family resides, automobiles used regularly by a patient or immediate family members, retirement and deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, college savings accounts, the first ten thousand dollars ($10,000) per family member of a patient's family's monetary assets and 50 percent of a patient's family's monetary assets over the first ten thousand ($10,000) per family member.

2.5. **Bad Debt** Expenses resulting from treatment for services provided to a patient and/or guarantor who, having the requisite financial resources to pay for health care services, has demonstrated by his/her actions an unwillingness to comply with the contractual arrangements to resolve a bill.

2.6. **Charge**. The uniform price set by the Hospital for a specific service or supply by the Hospital.

2.7. **Charity Care** No-cost inpatient and outpatient medical treatment and diagnostic service for uninsured or underinsured patients who cannot afford to pay for the care. Such treatment is provided without expectation of payment. Charity Care does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments or deductibles, or both. All payments meant to reimburse for the care of low income patients, such as disproportionate care hospital payments and Medicare graduate medical education payments should be netted out prior to calculating the hospital's level of charity care provided; that is, charity care standards should be based on the cost of unreimbursed care. Care provided under a Hill-Burton obligation is not counted as Charity Care under this definition.

2.8. **Collection Action** Any activity by which the Hospital, a designated agent or assignee of the Hospital, or a purchaser or the patient account, requests payment for services from a patient or a patient's guarantor. Collection actions include pre-admission and pretreatment deposits, billing statements, letters, electronic mail, telephone and personal contacts related to the Hospital bills, court summonses and complaints and any other activity related to collecting a Hospital bill.

2.9. **Cost of Service or Supply** The actual amount of money the Hospital spends to provide each service or supply.

2.10. **Cost-to Charge Ratio** The ration of the Hospital's total cost of providing patient care to its total charges for patient care, as reported in its most recently settled Medicare Cost Report.

2.11. **Family Income** The sum of annual earnings and cash benefits from all sources after taxes, minus payments made for alimony, child support, and student loans.

2.12. **Fair Accessible Individual Rate (FAIR) Care** includes "Charity Care," "Reduced Price Care" and "Medical Hardship Assistance." All available medically necessary health care services including inpatient and outpatient treatment, medical equipment, in-home services, laboratory services, and medications shall be available to all individuals under this Program.

2.13. **Federal Poverty Leve**l The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

2.14. **Medically Necessary Service** A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity. Medically Necessary Services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act.

2.15. **Patient's Family** means the following:

2.15.1. For persons 18 years of age and older, spouse, domestic partner and dependent children under 21 years of age, whether living at home or not.

2.15.2. For persons under 18 years of age, parent, caretaker relatives and other children, under 21 years of age, of the parent or caretaker relative.

2.16. **Reduced Price Care** Discounted inpatient and outpatient medical treatment and diagnostic services for uninsured or underinsured patients according to criteria set forth in § 3(B) below.

2.17. **Underinsured** A patient, including individuals in public insurance programs, whose deductibles, copayments, spend down, medical, or hospital bills after payment by third –party payers exceeds 5% of patient's income in the prior 12 months.

2.18. **Uninsured** A patient who does not have health insurance and is not currently covered by any third-party payer program. This includes persons whose coverage is terminated while receiving services at a hospital and is thus individually liable for a portion of the bill.

3. Policy.

3.1. **Basis of Financial Liability.**
Any amount owed by an uninsured or underinsured individual will be calculated using the hospital's cost of providing the care or by using the Medicare reimbursement rate, whichever is lower.

3.2. **FAIR Care Provision.**
This hospital shall provide annually no less than 5% of its annual patient operating revenues or expenses, whichever is greater, in FAIR care which includes Charity Care, Reduced Price Care, and Medical Hardship Assistance measured as the lower of: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual unreimbursed cost to the hospital for such service. The cost- to- charge ratio in the hospital's most recently settled Medicare Cost report shall be used to determine the hospital's unreimbursed cost of providing charity care.

3.3. **Non-discrimination.**
This hospital shall render services to all members of the community who are in need of medical care regardless of the ability of the patient to pay for such services. The determination of FAIR Care will be based on the patient's ability to pay and will not be abridged on the basis of age, sex, race, creed, disability, sexual orientation or national origin.

3.4. **Determination of Eligibility.**
The determination of FAIR Care should be made at or before the time of providing services. If complete information on the patient's insurance or financial situation is unavailable at the time of service, or if the patient's financial condition changes, the designation of FAIR Care may be made after rendering services. All efforts will be made to establish whether the patient is eligible for FAIR Care before leaving the hospital.

3.5. **Confidentiality.**
The need for FAIR Care may be a sensitive and deeply personal issue for recipients. Confidentiality of information and preservation of individual dignity shall be maintained for all who seek charitable services. Orientation of staff and the selection of personnel who will implement this policy and procedure should be guided by these values. No information obtained in the patient's FAIR Care application may be released unless the patient gives express permission for such release.

3.6. **Staff Information.**
All hospital employees in patient accounting, billing, registration, and emergency areas will be fully trained in the hospital's FAIR Care policy, have access to the application forms, and be able to direct questions to the appropriate hospital representatives.

3.7. **FAIR Care Representative.**
The hospital shall designate an individual to approve FAIR Care applications, coordinate outreach efforts and oversee FAIR Care practices.

3.8. **Physician Participation.**
The hospital will encourage and support physicians with admitting privileges and others who provide services at the hospital to provide a certain level of FAIR Care for patients that the practitioner sees on the hospital premises.

3.9. **Staff Training.**
All staff with public and patient contact are trained to understand the basic information related to the hospital's FAIR Care policy and procedures and provide patients with printed material explaining the FAIR Care Program.

3.10. **Uniformity.**
All hospitals affiliated with this facility will have identical FAIR Care policies.

4. Application Process.

4.1. **Application.**
The Hospital shall use attached application for patients to apply for FAIR Care from the hospital (Appendix A). Patients who do not have insurance may qualify for FAIR Care based on their monthly or annual income and their family size. Patients having insurance may also be eligible for FAIR Care for the portion of their bill that is not covered by insurance, including deductibles, coinsurance, and non-covered services.

4.2. **Application Assistance.**
The hospital's FAIR Care Representative (as provided under § 3.7) will provide application assistance to patients. Translation services and assistance will be offered to all patients.

4.3. **Requests for Information.**
The hospital shall send anyone who requests information on the hospital's FAIR Care Program a letter describing its Free and Reduced Price care program and application form. (Appendix A & B).

4.4. **Additional Requestors.**
FAIR Care requests may be proposed by sources other than the patient, such as the patient's physician, family members, community or religious groups, social service organizations, or hospital personnel. The patient shall be informed of such a request. This type of request shall be processed like any other.

4.5. **Timing.**
All attempts should be made by the hospital to have the patient fill out a FAIR Care application at or before the time services are rendered. A patient may file an application at any time.

5. FAIR Care Eligibility Categories.

5.1. **Charity Care** Upon review of the patient's financial and employment situation as completed in the FAIR Care application, the hospital will determine whether the patient qualifies for Charity Care. Uninsured Patients and Underinsured Patients whose family income is up to 300% of the Federal Poverty Income Guidelines, (See Appendix C) shall be eligible for Charity Care.

5.2. **Reduced Price Care** Uninsured Patients and Underinsured Patients whose family income is from 300% to 500% of the Federal Poverty Income Guidelines shall be eligible for Reduced Price Care from the Hospital.

5.2.1. **Annual Reduced Price Fee**

5.2.1.1. The Hospital shall calculate an Annual Reduced Price Deductible for the patient and the patient will be eligible for Charity Care after he or she has incurred expenses in the amount of the annual fee. The deductible shall equal 5% of the difference between the patient's Family Income and 300% of the Federal Poverty Income Guidelines.

5.2.1.2. There is one Annual Reduced Price Deductible amount per Family per 12 month period. Allowable medical expenses

billed by other providers during the same 12 month period shall be counted toward the deductible.

5.2.1.3. Allowable medical expenses billed by the Hospital shall be calculated at the lower of: (i) the lowest rate that would be paid by Medicare/Medicaid or (ii) the actual unreimbursed cost to the hospital for such service.

5.2.1.4. The Hospital shall bill a patient only for the Annual Reduced Price Deductible amount. The patient will be afforded the opportunity to pay that amount over a reasonable period of time.

5.3. **Medical Hardship Assistance** Uninsured Patients and Underinsured Patients at any income level whose allowable medical expenses have depleted family income to the extent that he or she is unable to pay for medically necessary services. In order to qualify for the medical hardship assistance the patient shall meet both the expense and resource qualifications below.

5.3.1. Expense Qualification. In order to be eligible for Medical Hardship Assistance, the patient's Allowable Medical Expenses must exceed 25% of his or her net Family Income after State and Federal taxes have been paid.

5.3.1.1. The Hospital shall multiply the Net Family Income by 25% and compare that amount to the total amount of the patient's Allowable Medical Expenses.

5.3.1.2. If the total of Allowable Medical Expenses is greater than 25% of the Net Family Income, the patient meets the expense qualification.

5.3.2. Resource Qualification. The patient's Available Assets must be insufficient to cover the cost of Allowable Medical Expenses that exceed 25% of the Family Income.

5.4. **Restrictions on Actions by Hospital.** In cases in which the patient is ineligible for Charity Care, Reduced Price Care and Medical Hardship Assistance, the hospital will administer the account and the individual's note shall be interest-free. In all instances, the hospital will work with the patient to determine an equitable payment schedule considering the patient's financial and medical circumstances. Accounts of alternative payment patients are not sent to a collections agency until no payment has been made for 180 days and the applicant has made no effort to apply for FAIR Care.

6. Application Review Process.

6.1. Financial Information.

If verification of financial information is needed, the hospital shall request such information from the patient. Patients may use a variety of information to substantiate financial circumstances, such as paycheck stubs, W-2 forms, income tax returns, receipts, employer letter, self-employed files, and unemployment or disability statements. If those items are unavailable, an affidavit from the patient will be sufficient.

6.1.1. **Asset Exemption.** The residence in which a patient and/or the patient's family resides, automobiles used regularly by a patient or

immediate family members, retirement and deferred compensation plans qualified under the Internal Revenue Code, non-qualified deferred compensation plans, college savings accounts, the first ten thousand dollars ($10,000) per family member of a patient's family's monetary assets and 50 percent of a patient's family's monetary assets over the first ten thousand ($10,000) per family member, are always exempted from consideration as assets in considering whether the patient meets the FAIR Care financial criteria.

6.2. **Approval.**

6.2.1. **Approval Notification.**
The patient shall be notified in writing within ten (10) working days after receipt of the Application and any supporting materials as to whether the patient is eligible for FAIR Care. When the patient is notified that s/he is eligible for FAIR Care, the hospital shall also notify the patient in writing that FAIR Care eligibility extends for one year and issue a uniform eligibility card. (Appendix D).

6.2.2. **FAIR Care Likelihood.**
If there is reason to believe that the patient is eligible for FAIR Care, i.e., the patient is uninsured, unemployed and/or homeless, the patient's record will be flagged and no bill will be sent until the question regarding FAIR Care eligibility is resolved.

6.2.3. **Continuing Eligibility.**
If the patient has applied and obtained FAIR Care within the last twelve (12) months and the patient's financial circumstances have not changed, the patient shall be deemed eligible for FAIR Care without having to submit a new FAIR Care application.

6.2.4. **Expired Patients.**
Patients who have died and have no estate are deemed to have no income for the purpose of determining FAIR Care eligibility.

6.3. **Denial.**
If the hospital determines that a patient is ineligible for FAIR Care, the hospital shall inform the patient in writing within five (5) working days of the denial. All reason(s) for denial shall be provided at that time and the patient shall be informed of the appeal process under §6.4. (Appendix E)

6.4. **Appeal.**
The Hospital will establish an independent FAIR Care Eligibility Review Department. (Department) Each patient denied FAIR Care may petition the Department within ninety (90) days for reconsideration. The Department shall send a copy of the complaint to the Hospital and ask for the Hospital's written response. (Appendix F).

7. Publication.

7.1. **Publication Inside Hospital.**

7.1.1. **Posters.**
The availability of FAIR Care shall be advertised on poster-sized (2' x 3') signage with at least 48 point font, located in Admissions, Outpatient Registration, Discharge, Emergency Room, Business

Office, Day Care and waiting room areas (Appendix G). A toll-free phone number will be included. Information on the sign will be translated into languages appropriate to the community.

7.1.2. **Business cards.**
Business cards notifying patients of the FAIR Care Program and flexible payment schedules will be located in the Admissions, Outpatient Registration, Discharge, Emergency Room, Business Office, Day Care and waiting areas and printed in the appropriate languages for the community (Appendix H). A toll-free phone number will be included.

7.1.3. **Information Sheet.**
Information sheets outlining the FAIR Care Program, application process and toll-free phone number shall be available at all patient registration desks and in all waiting areas. This information will be available at the sixth grade reading level. (Appendix I)

7.2. **Publication Outside Hospital.**

7.2.1. **Posting.**
Information regarding the availability of FAIR Care at the hospital shall be posted on signs throughout the service area.

7.2.2. **Public Health Department.**
Information regarding the hospital's FAIR Care Program, policy and application forms shall be provided to the local Department of Public Health and sent to local churches, domestic violence shelters, public schools, programs offering support to the homeless population and other relevant community based organizations.

7.2.3. **Publication.**
The hospital's FAIR Care Program shall be published on a quarterly basis in at least one newspaper of general circulation in the hospital's primary and secondary service areas. The notice shall include a description of the types of services that are offered and the financial criteria used to make eligibility determinations. The notice shall include an invitation for the public to make comments and provide suggestions regarding the hospital's FAIR Care Program, including directions on how to submit comments.

7.2.4. **Broadcasting.**
The hospital will provide information annually regarding the hospital's FAIR Care Program to local radio and television stations for release through the station's public service announcements (Appendix J).

7.3. **Translation.**
All publications and informational materials related to the FAIRCare Program will be translated into languages appropriate to the hospital's community.

8. <u>Notification.</u>

8.1. **Patient Notification Inside Hospital.**
The hospital shall provide all patients with oral and written notice of the hospital's FAIR Care Program in the language spoken by the patient during any pre-

admission, admission, and discharge process (Appendix K). This information will be available at or below a sixth grade reading level.

8.2. **Patient Notification with Bill.**
On all bills sent to patients a statement will be included regarding the availability of various assistance programs including FAIR Care and a contact number (Appendix L). This information will be available at or below a sixth grade reading level.

8.3. **Patient on Payment Plan Notification.**
Any patient who is on a payment plan and whose payment is 30 days late shall be sent information on FAIR Care.

9. Collection Activity.

9.1. **Restriction on Referral.**
The hospital, any agents of the hospital, and any assignee shall not use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills. The hospital will not refer patients to collections or report adverse information to a consumer credit agency until at least 180 days after FAIR Care and other payment programs are offered and any application for such programs is processed. The hospital will not refer a patient to outside collection unless there is a demonstrated ability to repay a significant portion of the debt, all insurance and/or other payors have completed processing of the claim, and the patient has applied for FAIR Care and been determined ineligible. The hospital shall impose these restrictions by contract on any entity to whom it sells or assigns the debt.

9.2. **Equitable Payment Schedule.**
In all instances, the hospital will work with the patient to determine an equitable payment schedule considering the patient's financial and medical circumstances. Any payment plans offered by the hospital to assist patients eligible under the hospital's FAIR Care policy, or any additional policy adopted by the hospital for assisting low-income patients with no or inadequate insurance in settling outstanding past due hospital bills, shall be interest-free.

9.3. **FAIR Care Notification.**
The hospital shall not send a patient to collections before it notifies the patient about the availability of FAIR Care and allows at least 180 days in which to apply for Charity Care, Reduced Price Care and Medical Hardship Assistance. Such notice shall be sent via certified mail.

9.4. **Prohibition on Medical Record Notation.**
The hospital shall make no notations in the patient's medical record regarding financial matters, including whether the patient paid all or part of any medical bill.

9.5. **Applicability to Existing Hospital Bills.**
The hospital shall send each patient with outstanding hospital bills on the effective date of this program, a letter explaining how to qualify for FAIR Care, and how to get more information (Appendix A & M).

10. Recordkeeping.

10.1. **Internal Recordkeeping.**
All Applications shall be logged in each hospital's "FAIR Care control log" and shall be given a sequential control number. The completed Applications will be

kept on file for five (5) years. A copy of the patient's Application and all correspondence with the patient regarding the Application, approval, denial and appeal shall be maintained in the patient's financial file

10.2. **Accounting.**
Charity Care, Reduced Price Care, and Medical Hardship Assistance shall be recorded using the direct write-off method and shall comply with all accounting regulations by the American Institute for Certified Public Accounting.

11. Reporting.

11.1. **External Reporting.**
The hospital shall in its annual financial statements include a copy of the hospital's FAIR Care policy, the amount of Charity Care, Reduced Price Care, and Medical Hardship Assistance provided in cost and charges, and the data detailed in this Section; post such information on the hospital web site and make it available to any member of the public requesting the data.

11.2. **Charity Care Provision – Aggregate Data**
The hospital annually shall aggregate and make anonymous information regarding the provision of Charity Care , Reduced Price Care, and Medical Hardship Assistance including:

11.2.1. The total number of Applications granted and denied by zip code and ethnicity.

11.2.2. The number of Charity Care, Reduced Price Care, and Medical Hardship appeals filed and granted by zip code and ethnicity.

11.2.3. The total number of uninsured and underinsured patients served each year.

11.2.4. A breakdown of the percentage of emergency or scheduled services provided as Charity Care compared to the total amount.

11.2.5. A breakdown of the percentage of care provided as inpatient, outpatient, or ancillary Charity Care compared to the total amount.

11.2.6. The total number of Charity Care, Reduced Price Care, and Medical Hardship patient days.

11.2.7. A listing of all diagnoses for Charity Care, Reduced Price Care, and Medical Hardship Care patients.

11.2.8. The total number of referrals made to other facilities, their names, and a list of reasons for referrals.

11.2.9. The total cost of Charity Care, Reduced Price, and Medical Hardship Care delivered for the hospital's fiscal year.

11.3. **FAIR Care Provision – Descriptive Data**

The following also shall be included in the FAIR Care annual report:

Charity Care- Proportion Data

a) "In [year], xx% of all services was provided on a charity care basis".
b) "In [year], xxx inpatients out of xxx total and xxx outpatients out of xxx total received charity care."

c) “The largest proportion of services provided on a Charity Care basis was (describe service, such as cancer, emergency services, etc.)”

Reduced Price Care Proportion – Data

a) “In [year], xx% of all services was provided on a Reduced Price Care basis”.
b) “In [year], xxx inpatients out of xxx total and xxx outpatients out of xxx total received Reduced Price Care.”
c) “The largest proportion of services provided on a Reduced Price Care basis was (describe service, such as cancer, emergency services, etc.)”

Medical Hardship Assistance Care Data

a) “In [year], xx% of all services was provided on a Medical Hardship Care basis”.
b) “In [year], xxx inpatients out of xxx total and xxx outpatients out of xxx total received Medical Hardship Assistance Care.”
c) “The largest proportion of services provided on a Medical Hardship Care basis was (describe service, such as cancer, emergency services, etc.)”

11.4. **Public Access.** The hospital shall make this information available to the public upon request. (Appendix O).

12. <u>Corporate Responsibility.</u>

The principal executive officer or officers and the principal financial officer or officers, or persons performing similar functions, shall certify in each annual financial report and report filed with state and local agencies that includes information about FAIR Care, that the signing officer has reviewed the report and based on the officer's knowledge, the report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements.

Appendix A

FAIR Care Application Form

1. Applicant Information.

Last Name First Name MI	FAIR Care Sequential Control Number (“FCSN,” completed by hospital)
Street Address	Telephone Numbers Home Work Cell
City State Zip Code	Mailing Address (if different from Street Address)
Date of Birth	ف Male ف Female / Are you pregnant? Yes ف No ف

Are you: homeless? Yes ف No ف
unemployed? Yes ف No ف
uninsured? Yes ف No ف

2. If you are applying for someone else, complete this section.

Last Name First Name MI	Relationship to Applicant:
Street Address	Telephone Numbers Home Work Cell
City State Zip Code	Mailing Address (if different from Street Address)

3. Family Information. List the people in your family that live with you and you support with your income. Include your spouse, dependent children under age 18, and dependent elders that live with you. If this application is for a child under age 18, include brothers or sisters under 18 and the child’s parent or parents who live with you.

Name of Family Member	Relationship	Date of Birth	Gender	Pregnant
			M ف F ف	Y ف N ف
			M ف F ف	Y ف N ف
			M ف F ف	Y ف N ف
			M ف F ف	Y ف N ف
			M ف F ف	Y ف N ف

4. **List Earned Income** before taxes and deductions for each family member who works.

Name of Working Family Member	Employer Name & Address	Amount Earned	How Often? Weekly/Monthly/Annually

5. **Other Income not from an employer.**

Type of Income	Family Member Receiving Income	Amount	How often? Weekly/Monthly/Annually
Social Security			
Railroad Retirement			
Veterans' Benefits			
Retirement Funds			
Annuities			
Pensions			
Child Support			
Alimony			
Unemployment			
Workers Compensation			
Rental Income			
Trust Income			
County General Relief			
Refugee Resettlement Program			
Dividend Income			
Bank Account Income			
Other Income, please specify			

6. **Other Expenses.** Fill in this section if you or anyone in Section 3 is required to make payments for alimony, child support, or personal needs allowance for a family member in a nursing home.

Payment Type	Recipient Name/Relationship	Amount Paid	How often? Weekly/Monthly/Annually
Alimony			
Child Support			
Personal Needs Allowance			

7. **Other Insurance.** Charity Care can pay for such things as your co-payments and deductibles even if you have other health insurance

a. Are you covered under any health insurance policy, including Medicare? Y ق N ق If yes:

Policy Holder (Name)	Insurance Company	Policy Number

b. Are you seeking FAIR Care because of a work-related accident or injury? Y ف N ف
c. Are you seeking FAIR Care because of a car accident? Y ف N ف
d. Are you a student? Y ف N ف If yes, are you full time? ف part time? ف
e. Do you have an application pending for any of these programs? *(Check all that apply)*
   Medicaid ف
   Medicare ف
f. Are you currently approved for Charity Care, Reduced Price Care or Medical Hardship Assistance at another hospital or community health center?
   Y ف N ف If yes, where?____

8. Medical Bills. Total medical bills ____
Why can't you pay your medical expenses? Why do you need FAIR Care? ________________
____
____
____
____

9. Ethnicity/Race. Ethnicity/Race will not be used to determine eligibility.
- ❑ Asian or Pacific Islander
- ❑ African-American, not Latino
- ❑ Latino
- ❑ American Indian or Alaskan Native
- ❑ Caucasian, not Latino
- ❑ Other________________________________
- ❑ I do not wish to answer.

This is for data collection and analysis purposes only.

10. Assignment of Rights. Read this section carefully and sign.
I agree to tell this hospital about changes to my family status including family size, income, and insurance coverage that could change my eligibility for FAIR Care.

All information in this application is true to the best of my knowledge. I agree to provide documentation upon request.

I understand that this hospital cannot share confidential information with any state or federal agency without my prior approval.

______________________________ __________________
Signature of applicant Date

______________________________ __________________
Signature of authorized representative Date

If you have questions about this application, contact the FAIR Care Representative at 1-800-*XXX-XXXX*.

Mail the completed application to:

FAIR Care Processing Department
Address

Appendix B

Letter to Patient Regarding FAIR Care Availability

Dear Patient:

You may be eligible for medical care even if you cannot pay for it.

This hospital has a FAIR Care program for patients who cannot afford to pay for medical care. Eligibility for the program is based on your family's income and the number of people in your family. It may also be based on whether your medical expenses would constitute a medical hardship.

In order to be considered for care you need but cannot pay for, please complete the attached application form. If you have any questions or need assistance in completing this application, please contact the FAIR Care Representative at 1-800-*XXX-XXXX*. If you cannot complete the form, you may have an authorized representative fill it out for you.

Please send your application to:

FAIR Care Processing
Contact Name
Department
Address

We will notify you within ten (10) business days as to whether your FAIR Care application has been approved.

If you are denied FAIR Care, you may: 1) appeal the denial; 2) re-apply for FAIR Care at any time if your financial situation changes; or 3) work out a payment plan with our patients account office, considering your existing financial obligations.

Thank you.

Appendix C

FAIR Care Eligibility Based on 2007 Federal Poverty Guidelines

2007 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.	Alaska	Hawaii
1	$10,210	$12,770	$11,750
2	13,690	17,120	15,750
3	17,170	21,470	19,750
4	20,650	25,820	23,750
5	24,130	30,170	27,750
6	27,610	34,520	31,750
7	31,090	38,870	35,750
8	34,570	43,220	39,750
For each additional person, add	3,480	4,350	4,000

SOURCE: *Federal Register*, Vol. 72, No. 15, January 24, 2007, pp. 3147–3148

Appendix D

Notification for Patients Eligible for FAIR Care

Notification Letter

Dear Patient,

You are eligible to receive FAIR Care from this hospital for the next year. Enclosed is a card. It states that you are eligible for FAIR Care. You are eligible for FAIR Care for one year, from Month ____ Day ____ Year ____ to Month____ Day ____ Year____.

Notify the hospital immediately if your situation changes and you can afford to pay for your medical care.

If you have further questions, call the FAIR Care Representative at 1-800-*XXX-XXXX*.

Thank you.

Eligibility Card

Front

FAIR Care Card
Hospital Name
I am eligible for health care under the hospital's FAIR Care Policy.
I am eligible for
Charity Care____
Reduced Price Care with Deductible Amount____
Deductible Met on (date) ____
Medical Hardship Assistance___

Back

Name ______________________________
Address ______________________________
____
Phone Number ______________________
I am eligible for free care until _______ .
(one year from: ______ to:______)

Appendix E

Denial Letter / Appeal Form
(Translated)

Dear Patient:

This hospital cannot provide you coverage with FAIR Care at this time because:

____
____
____
____
____
____
____

You can:

1. Appeal this denial of FAIR Care by completing the Appeal Application. Mail it to:

   FAIR Care Appeals
   Contact Name
   Department
   Address

   The hospital will notify you within ten (10) business days if your Appeal is approved.

2. If your financial circumstances change, you may be eligible for FAIR Care. Please reapply if your income or expenses change.

3. You may be eligible for a reduced payment plan. Contact the Patient Accounts Office at 1-800-*XXX-XXXX* to discuss this.

You are allowed by law to get Emergency Medical Care from the hospital.

If you have further questions, call 1-800-*XXX-XXXX*.

Sincerely,

Name

Appendix F

FAIR Care Appeal Form

Complete this form if you have been denied FAIR Care and want your case reconsidered.

If you have questions about this form contact 1-800-*XXX-XXXX*.

Please mail the completed form to:

FAIR CARE Eligibility Review Department
Appeals
Contact Name
Address

Your Name____
Address ____
____
____
____
Patient Number ____
Services Provided / Dates of Service ___________________________
____
____

1. I am appealing the denial of FAIR Care. I request that my FAIR Care application be reconsidered for the following reasons. ___________________
____
____
____
____
____
____
____
____
____
____
____
____

Date this Appeal is submitted: ____________

Signature_____________________________

Appendix G

Posters Located Throughout Hospital / Service Area
(Translated)

FAIR CARE

We believe all people should get
medical care
whether or not they can pay.
If you cannot pay
your medical expenses,
you may qualify for the
hospital's FAIR Care program.
For more information, contact us:
1-800-XXX-XXXX

Appendix H

Business Cards Located Throughout Hospital
(Translated)

FAIR Care
This hospital is committed to providing
health care to all people
regardless of ability to pay.
If you have questions or need financial
Please contact us at:
1-800-XXX-XXXX.

Appendix I

Information Sheet Describing FAIR Care Policy and Application Process

Can't pay your hospital bill?

What if I can't pay my hospital bill?
If you don't have health insurance or if your insurance doesn't cover all your medical expenses, let us know. We believe all people should get medical care whether or not they can pay.

How do I apply for FAIR Care?

Call and ask for an application.

1-800-*XXX-XXXX*

We can answer your questions and help you fill out your application.

And, we can help you apply for public health care programs.

How does the hospital decide if I qualify?

We look at your family's income and how many people are in your family. We will not look at your age, sex, race, beliefs or disabilities. Depending on your circumstances, you may be eligible for Free Care, Reduced Price Care or Medical Hardship Assistance.

What happens if I qualify?

As long as your financial situation does not change your eligibility remains in effect for one year. If you qualify for Charity Care, you can get Charity Care for one year.
If you are eligible for Reduced Price Care, you will pay one annual deductible for your family. You will not have to pay for any medical expenses for one year after you meet your deductible. If you qualify for medical hardship, you will not pay for any medical expenses for one year.

How do I know if I qualify?

We will mail you a card within 10 business days of getting your application. Or, we may ask you for more information.

What if I don't qualify?

You can:

- Appeal—Fill out the appeal form you get with the denial letter and we will tell you our decision within 10 business days; or
- Apply again—If your income has changed, you may qualify; or
- Ask the hospital to let you make payments.

For more information, contact us:

1-800-*XXX-XXXX*

Hospital Name
Address
Address2

Appendix J

FAIR Care Public Service Announcement

(*Hospital name*) is a responsible member of this community. We are dedicated to improving the health of our community. We are committed to making sure that everyone has access to medical care regardless of ability to pay.

We offer care for people who are not able to pay for medical services. If you have medical needs and cannot pay, or if you know of someone who cannot pay for medical services call 1-800-*XXX-XXXX* and ask about (*hospital name*)'s FAIR Care program.

If you quality, you can get FAIR Care for one year, and you won't have to pay the hospital back (unless your financial situation changes). We have people who can help you apply or talk to you about other public health care programs.

That number again is 1-800-*XXX-XXXX*.

Appendix K

Statement for Oral Notification

If you cannot pay for your medical services, you may be eligible for care through the hospital's FAIR Care program. This is an application or you can call 1-800-*XXX-XXXX* for more information.

Statement for Written Notification

If you cannot pay for your medical services, you may be eligible for care through the hospital's FAIR Care program. For more information about if you qualify, call 1-800-*XXX-XXXX*.

Appendix L

Statement Included in All Medical Bills

We believe all people should get medical care whether or not they can pay. If you do not have health insurance or if your insurance doesn't cover all your medical expenses, you may qualify for help through the hospital's FAIR Care program.

Please contact the FAIR Care Representative at 1-800-*XXX-XXXX*. We can discuss whether you qualify for state and federal assistance programs including Medicare and Medicaid. You may also request a FAIR Care application if you will have trouble paying your medical bills.

Appendix M

Letter to Patient in Collections after Hospital Adopts New FAIR Care Program

Dear Patient:

You may be eligible for medical care without paying for it.

This hospital recently started a FAIR Care Program. We offer medical care to patients who are unable to pay. You are eligible based on:

your family's income,
the number of people in your family,
if your medical bills would be a hardship.

To be considered for FAIR Care or medical care you need but cannot pay for, complete the Application Form.

If you have any questions or need help completing this application, contact the FAIR Care Representative at 1-800-*XXX-XXXX*. If you can't complete the form, your representative can fill it out for you.

Send your application to:

FAIR Care Processing
Contact Name
Department
Address

In ten (10) business days the hospital will tell you if your FAIR Care application has been approved.

If you are denied FAIR Care, you may:
1) appeal;
2) re-apply at any time if your financial situation changes;
3) work out a payment plan with our Patient's Account Office.

Thank you.

Name

Thank you.

Appendix N

FAIR Care Patient Log

1 FAIR Care Sequential Control Number.

2. Eligibility
   21. Eligible for Charity Care
   2.2 Eligible for Reduced Price Care with Deductible Amount
   2.3 Eligible for Medical Hardship
   2.4 Not Eligible for FAIR Care

3 Demographic Data.
   - 2.1 Patient identification number
   - 2.2 Sex
   - 2.3 Zip code of residence
   - 2.4 Ethnicity
   - 2.5 Household Size
   - 2.6 Primary Language

3 Service Data.
   - 3.1 Date of service / admit date
   - 3.2 Type of service (including whether it was emergency or scheduled)
   - 3.3 Type of care delivered including whether it was inpatient, outpatient, or ancillary
   - 3.4 Number of inpatient days
   - 3.5 Diagnosis
   - 3.6 Cost of care delivered
   - 3.7 The name of the facilities to which an individual requesting or applying for FAIR Care was referred and reason for referral.

4 Financial Data.
   - 4.1 Household gross monthly income
   - 4.2 Household principal income source

5 Charity Policy Data.
   - 5.1 Timing of determination with care (before admission, during hospital stay, after discharge, before bill was sent).
   - 5.2 Timing of determination with application (upon first request, upon appeal).

Appendix O

FAIR Care Annual Report

This hospital shall publish an annual FAIR Care report which should include the following::

1 The total number of FAIR Care applications granted and denied by zip code and ethnicity.
2 The number of FAIR Care appeals filed and granted by zip code and ethnicity.
3 The percentage of emergency or scheduled services provided as FAIR Care compared to the total amount provided.
4 The percentage amount of care provided as inpatient, outpatient, or ancillary FAIR Care compared to the total amount provided.
5 The total number of FAIR Care patient days.
6 A compilation of all diagnoses for FAIR Care patients.
7 The total number of referrals made to other facilities, their names, and a list of reasons for referrals.
8 The total cost of care delivered (using the cost-to-charge ratio specified in definition J of the FAIR Care policy) for the hospital's fiscal year.

9. Charity Care- Proportion Data

a) "In [year], xx% of all services was provided on a charity care basis".

b) "In [year], xxx inpatients out of xxx total and xxx outpatients out of xxx total received charity care."

c) "The largest proportion of services provided on a Charity Care basis was (describe service, such as cancer, emergency services, etc.)"

10. Reduced Price Care Proportion – Data

a) "In [year], xx% of all services was provided on a Reduced Price Care basis".

b) "In [year], xxx inpatients out of xxx total and xxx outpatients out of xxx total received Reduced Price Care."

c) "The largest proportion of services provided on a Reduced Price Care basis was (describe service, such as cancer, emergency services, etc.)"

11. Medical Hardship Assistance Care Data

a) "In [year], xx% of all services was provided on a Medical Hardship Care basis".

b) "In [year], xxx inpatients out of xxx total and xxx outpatients out of xxx total received Medical Hardship Assistance Care."

c) "The largest proportion of services provided on a Medical Hardship Care basis was (describe service, such as cancer, emergency services, etc.)"

Apéndice A

Formulario de solicitud para FAIR Care

1. Información del solicitante.

Apellido Nombre Inicial	Número de control de secuencia de FAIR Care (“FCSN,” Completado por el hospital)
Dirección residencial	Números de teléfono Casa Trabajo Celular
Ciudad Estado Código postal	Dirección postal (si es distinta a la Dirección residencial)
Fecha de nacimiento	ڤ Hombre ڤ Mujer / ¿Está embarazada? Sí ڤ No ڤ

Está: ¿sin hogar? Sí ڤ No ڤ
¿desempleado? Sí ڤ No ڤ
¿sin seguro? Sí ڤ No ڤ

2. Si está llenando una solicitud para otra persona, complete esta sección.

Apellido Nombre Inicial	Relación con el solicitante:
Dirección residencial	Números de teléfono Casa Trabajo Celular
Ciudad Estado Código postal	Dirección postal (si es distinta a la Dirección residencial)

3. Información familiar. Apunte las personas en su familia que viven con usted y que usted ayuda a mantener con sus ingresos. Incluya a su cónyuge e hijos dependientes menores de 18 años, al igual que adultos mayores dependientes que viven con usted. Si esta solicitud es para un menor de 18 años, incluya los hermanos y hermanas menores de 18 años y el padre o los padres del niño que viven con usted.

Nombre del miembro de la familia	Relación	Fecha de nacimiento	Género	¿Embarazada?
			M ڤ F ڤ	Sí ڤ No ڤ
			M ڤ F ڤ	Sí ڤ No ڤ
			M ڤ F ڤ	Sí ڤ No ڤ
			M ڤ F ڤ	Sí ڤ No ڤ
			M ڤ F ڤ	Sí ڤ No ڤ

4. Anote el ingreso ganado, antes de impuestos y deducciones, por cada miembro de la familia que trabaja.

Nombre del miembro de la familial que trabaja	Nombre y dirección del empleador	Ingreso	Frecuencia (Semanal/Mensual/Anual)

5. Otros ingresos que no provengan de un empleador.

Tipo de ingresos	Miembro de la familia que recibe el ingreso	Cantidad	Frecuencia (Semanal/Mensual/Anual)
Seguro Social			
Retiro Ferroviario			
Beneficios de veterano			
Fondos de retiro			
Anualidades			
Pensiones			
Sostén económico (hijos)			
Pensión alimenticia			
Desempleo			
Compensación de trabajadores			
Ingreso de alquiler			
Ingreso de fideicomiso			
Auxilio general del condado			
Programa para repoblación de refugiados			
Ingreso de dividendos			
Ingreso de cuenta bancaria			
Otros ingresos, especifique			

6. Otros gastos. Complete esta sección si usted o cualquier otra persona en la Sección 3 está obligada a hacer pagos de pensión alimenticia, sostén económico de hijos o complemento para necesidades personales para un familiar en un hogar de ancianos.

Tipo de pago	Nombre del beneficiario/Relación	Cantidad pagada	Frecuencia (Semanal/Mensual/Anual)
Pensión alimenticia			
Sostén económico de hijos			
Complemento para necesidades personales			

7. Otros seguros. Cuidado caritativo puede pagar por cosas tales como sus co-pagos y deducibles aún si tiene otros seguros.
a. ¿Está cubierto bajo cualquier póliza de seguro de salud, incluyendo Medicare? Sí ف No ف
Si contesta “sí”:

Beneficiario en la póliza (nombre)	Compañía de seguro	Número de la póliza

b. ¿Busca usted asistencia de FAIR Care debido a un accidente o lesión relacionados al trabajo? Sí ڤ No ڤ
c. ¿Busca usted asistencia de FAIR Care debido a un accidente de automóvil? Sí ڤ No ڤ
d. ¿Es estudiante?? Sí ڤ No ڤ De ser así, ¿está matriculado tiempo completo? ڤ ¿Tiempo parcial? ڤ
e. ¿Tiene una solicitud pendiente para cualquiera de estos programas? *(Marque todos los que apliquen)*
Medicaid ڤ
Medicare ڤ
f. ¿Está aprobado actualmente para recibir asistencia caritativa, cuidado a precio reducido o asistencia por dificultad médica en otro hospital o centro de salud comunitario?
Sí ڤ No ڤ De ser así, ¿en dónde?____

8. Cuentas médicas. Total de cuentas médicas ____
¿Por qué no puede pagar sus cuentas médicas? ¿Por qué necesita FAIR Care?
____
____
____
____

9. Origen étnico y raza. No se usará el origen étnico o la raza para determinar si califica o no .

- ❒ Asiático o Nativo de las Islas del Pacífico
- ❒ Afroamericano, no Latino
- ❒ Latino
- ❒ Indio Americano o Nativo de Alaska
- ❒ Blanco, no Latino
- ❒ Otro______________________________
- ❒ Prefiero no contestar.
  Esto es solamente para propósitos de recolección de datos y análisis.

10. Asignación de derechos. Lea esta sección cuidadosamente y fírmela.
Acepto informarle a este hospital de los cambios en mi estado familiar incluyendo el tamaño de la familia, ingreso y cobertura de seguros que pudieran afectar que califique para recibir FAIR Care.

Toda la información en esta solicitud es cierta según mi mejor entendimiento. Estoy de acuerdo en proporcionar documentación de ser esto necesario.

Entiendo que este hospital no puede compartir información confidencial con ninguna agencia estatal o federal sin mi consentimiento previo.

_____________________________ _________________
Firma del solicitante Fecha

_____________________________ _________________
Firma del representante autorizado Fecha

Si tiene preguntas sobre esta solicitud, comuníquese con el representante de FAIR Care en el 1-800-*XXX-XXXX*.

Envíe la solicitud completa a:

FAIR Care Processing Department
Dirección

Apéndice B

Carta al paciente sobre la disponibilidad de FAIR Care

Estimado paciente:

Usted puede tener derecho a recibir atención médica aún si no la puede pagar.

Este hospital tiene un programa de FAIR Care para pacientes que no pueden costear sus gastos médicos. Poder calificar para el programa depende de su ingreso familiar y el número de personas en su familia. También puede depender de si sus gastos médicos constituyen o no una penuria médica.

Para ser considerado para recibir atención médica necesaria pero que usted no puede pagar, favor de completar el formulario de solicitud adjunto. Si tiene preguntas o necesita asistencia para completar esta solicitud, por favor comuníquese con su representante de FAIR Care al 1-800-*XXX-XXXX*. Si no puede completar el formulario, puede pedirle a un representante autorizado que lo llene por usted.

Por favor envíe la solicitud a:

FAIR Care Processing
Nombre del contacto
Departamento
Dirección

Le notificaremos dentro de diez (10) días hábiles si su solicitud para FAIR Care ha sido aceptada.

Si es rechazado para obtener FAIR Care, usted puede: 1) apelar el rechazo; 2) solicitar FAIR Care de nuevo en cualquier momento que su situación financiera cambie; o 3) establecer un plan de pagos con nuestra oficina de cuentas del paciente, que tome en cuenta sus obligaciones financieras existentes.

Gracias.

Apéndice D

Notificación para pacientes que califican para recibir FAIR Care

Carta de notificación

Estimado paciente,

Usted tiene derecho a recibir FAIR Care de este hospital el próximo año. Adjunto encontrará una tarjeta que establece que usted puede recibir FAIR Care. Usted califica para recibir FAIR Care por un año, desde el Día ___ del Mes _____ del Año ____ hasta el Día ___ del Mes ____ del Año ____.

Notifique al hospital de inmediato si su situación cambia y ya puede pagar por su atención médica.

Si tiene preguntas adicionales, llame al representante de FAIR Care al 1-800-*XXX-XXXX*.

Gracias.

Tarjeta de derecho a Fair Care

I Frente

Tarjeta de FAIR Care
Nombre del hospital
Tengo derecho a recibir atención médica bajo la política de FAIR Care del hospital.
Tengo derecho a recibir cuidado caritativo ____
Cuidado a precio reducido con deducible
Cantidad ____
Deducible fue satisfecho en (fecha) ____
Asistencia por penuria médica ____

Dorso

Nombre ____
Dirección ____
____
Teléfono ____
Tengo derecho a recibir cuidado gratuito hasta ___________.
(un año desde: _______ a:_______)

Apéndice E

Carta de rechazo / Formulario de apelación
(Traducido)

Estimado paciente:

Este hospital no podrá proporcionarle cobertura bajo FAIR Care en la actualidad porque:

____
____
____
____
____
____
____

Usted puede:

1. Apelar este rechazo de FAIR Care llenando la Solicitud de apelación y enviándola a:

    FAIR Care Appeals
    Nombre del contacto
    Departamento
    Dirección

    El hospital le notificará dentro de diez (10) días hábiles si su apelación es aprobada.

2. Si sus circunstancias financieras cambian, usted puede tener derecho a FAIR Care. Por favor haga una nueva solicitud cuando sus ingresos o sus gastos cambien.

3. Usted puede tener derecho a participar en un plan de pagos reducidos. Comuníquese con la Oficina de Cuentas del Paciente al 1-800-*XXX-XXXX* para este asunto sea considerado otra vez.

Por ley, usted puede obtener servicios de emergencia médica del hospital.

Si tiene preguntas adicionales, llame al 1-800-*XXX-XXXX*.

Atentamente,

Nombre

Apéndice F

Formulario de apelaciones de FAIR Care

Por favor llene este formulario si ha sido rechazado para obtener FAIR Care y quiere que se reconsidere su caso.

Si tiene preguntas sobre este formulario, llame al 1-800-*XXX-XXXX*.

Por favor envíe el formulario completo por correo a:

FAIR CARE Eligibility Review Department
Appeals
Nombre del contacto
Dirección

Su nombre____
Dirección____
____
____
____
Número del paciente____
Servicios recibidos / Fechas de los servicios___________________________________
____
____

1. Estoy apelando el rechazo de FAIR Care. Pido que mi solicitud de FAIR Care sea reconsiderada por las siguientes razones.____
____
____
____
____
____
____
____
____
____
____
____

Fecha de la apelación:______________________________

Firma____

Apéndice G

Rótulos localizados a través del hospital / Área de servicio
(Traducido)

FAIR CARE

Creemos que todas las personas tienen derecho a recibir atención médica sin importar si pueden pagarla o no. Si usted no puede pagar sus gastos médicos, es posible que califique para el programa FAIR Care del hospital. Para más información, llámenos al:

1-800-XXX-XXXX

Apéndice H

Tarjetas de negocio localizadas a través del hospital
(Traducido)

FAIR Care

Este hospital se compromete a proporcionar

servicios de salud a todas las personas sin tomar

en cuenta su habilidad de pagar.

Si tiene preguntas o necesita ayuda financiera,

favor de llamar al

1-800-XXX-XXXX.

Apéndice I

Hoja informativa que describe la política y el proceso de solicitud de FAIR Care

¿No puede pagar su cuenta de hospital?

¿Qué sucede si no puedo pagar mi cuenta de hospital?

Déjenos saber si no tiene seguro médico o si su seguro no cubre todos sus gastos médicos. Creemos que todas las personas deben poder recibir cuidado médico sin importar su habilidad de pagar.

¿Cómo solicito para participar en FAIR Care?

Llame y pida una solicitud.
1-800-*XXX-XXXX*

Podemos contestar sus preguntas y ayudarle a llenar su solicitud.
Además, podemos ayudarle a solicitar asistencia de programas de salud pública.

¿Cómo decide el hospital si califico?

Tomamos en consideración su ingreso familiar y el número de personas en su familia. No tomamos en cuenta su edad, sexo, raza, creencias religiosas o discapacidades. Dependiendo de sus circunstancias, usted pudiera ser elegible para recibir cuidado gratuito, cuidado a precio reducido o asistencia por penuria médica.

¿Qué sucede si calilfico?

Mientras que su situación financiera no cambie, su elegibilidad continuará en efecto por un año. Si califica para cuidado caritativo, usted podrá obtener cuidado caritativo por un año. Si es elegible para recibir cuidado a precio reducido, usted pagará un deducible anual por su familia. Usted no tendrá que pagar ningún gasto médico por un año después de satisfacer su deducible. Si califica por penuria médica, usted no tendrá que pagar ningún gasto médico por un año.

¿Cómo puedo saber si califico?

Le enviaremos una tarjeta por correo dentro de 10 días hábiles después de recibir su solicitud. O quizás le pidamos más información.

¿Qué sucede si no califico?

Usted tiene derecho a:

- Apelar—Complete el formulario de apelación adjunto a la carta de rechazo y le dejaremos saber nuestra decisión dentro de 10 díashábiles; o
- Solicitar de nuevo—Si sus ingresos han cambiado, usted pudiera calificar; o
- Pedirle al hospital que le permita hacer pagos.

Para más información, contáctenos como sigue:

1-800-*XXX-XXXX*

Nombre del hospital
Dirección
Dirección 2

Apéndice J

Anuncio de servicio público de FAIR Care

El (nombre del hospital) es un miembro responsable de esta comunidad. Nos dedicamos a mejorar la salud de nuestra comunidad y nos comprometemos a garantizar que todos tengan acceso a atención médica sin importar su habilidad de pagar.

Ofrecemos atención médica aún para aquellos que no pueden pagar por estos servicios. Si tiene necesidades médicas y no puede pagarlas o si sabe de alguien que no puede pagar por servicios médicos, llame al 1-800-*XXX-XXXX* y pregunte por el programa FAIR Care del (nombre del hospital).

Si califica, podrá recibir FAIR Care por un año y no tendrá que pagarle al hospital posteriormente a menos que su situación financiera cambie. Contamos con personal que le puede ayudar a solicitar, o informarle sobre otros programas de servicios de salud pública.

Una vez más, el número es el 1-800-*XXX-XXXX*.

Apéndice K

Declaración de notificación oral

Si no puede pagar por sus servicios médicos, usted puede calificar para obtener cuidado a través del programa FAIR Care del hospital. Esta es una solicitud o usted puede llamar al 1-800-*XXX-XXXX* para obtener más información.

Declaración de notificación por escrito

Si no puede pagar por sus servicios médicos, usted puede tener derecho a recibir asistencia médica a través del programa FAIR Care del hospital. Para saber si califica, llame al 1-800-*XXX-XXXX*.

Apéndice L

Declaración incluida con todas las cuentas médicas

Creemos que todas las personas deben poder recibir atención médica sin importar si pueden pagarla o no. Si no tiene seguro médico o si su seguro no cubre todos sus gastos médicos, usted podría calificar para obtener ayuda a través del programa FAIR Care del hospital.

Favor de llamar al representante de FAIR Care al 1-800-*XXX-XXXX*. Podemos asesorarle sobre si usted califica para programas estatales y federales de asistencia, incluyendo Medicare y Medicaid. Usted también podrá llenar una solicitud para FAIR Care si tiene dificultad para pagar sus cuentas médicas.

Apéndice M

Carta a pacientes en actividad de cobros después de que el hospital adopta el nuevo programa FAIR Care.

Estimado paciente:

Usted pudiera ser elegible para obtener atención médica gratis.

Este hospital recientemente comenzó un programa de FAIR Care. Ofrecemos atención médica a pacientes que no pueden pagar. Usted puede calificar dependiendo de:

su ingreso familiar;
el número de personas en su familia,
si sus cuentas médicas representan una penuria.

Para ser considerado para participar en FAIR Care u obtener cuidado médico que usted necesita pero no puede pagar, llene el formulario de solicitud.

Si tiene preguntas o necesita ayuda para llenar esta solicitud, llame al representante de FAIR Care al 1-800-*XXX-XXXX*. Si no puede completar el formulario, su representante de FAIR Care puede ayudarle a llenarlo.

Envíe su solicitud a:

FAIR Care Processing
Nombre del contacto
Departamento
Dirección

En los siguientes diez (10) días hábiles, el hospital le informará si su solicitud para FAIR Care ha sido aprobada.

Si es rechazado para obtener FAIR Care, usted puede:
1) apelar;
2) solicitar nuevamente en cualquier momento que su situación financiera cambie;
3) establecer un plan de pagos con nuestra Oficina de Cuentas del Paciente (Patient's Account Office).

Gracias.

Nombre