HMH Charity Determination Calculator and Approval

HMH Financial Assistance Policy – Attachment D

Patient Name: _____ Account Number: _____ Total Charges: _____

Admission Date: _____ Discharge Date: _____

Patient Interview/Required Documentation Summary:

Family Size: _____ Annual Income: _____ % FPL: _____

_____ 0-100% Walker County = Indigent Care/County Program
_____ 101-200% Walker County = Charity Care
_____ 0-200% Out of County = Charity Care

Documentation Provided/Attached:

1. **_____ IRS Form, W-2, Wage and Earnings Statement, or Tax Return**
2. **_____ Paycheck Remittance, or Bank Statement Confirming Direct Deposit**
3. **_____ Social Security. Work Comp, or Unemployment Letter, Other Government Benefit**
4. **_____ Telephone Verification by Employer**
5. **_____ Written/Verbal Attestation (Patient signed Application, Attesting to Documented Income)**
6. **_____ Unable to Obtain Documentation (Patient Deceased)/Other**

Credit Profile:

Credit Score: _____ Capacity to Pay: _____Est Annual Income: _____ Calculated FPL%:_____

Applicable Exceptions (Charity Approved):

1. **_____ Exchange Plan Cost Exceeds 8% of Total Annual Income or Marketplace Certificate of Hardship**
   Total Income: _____ HIX Cost: _____ % of Income: _____

2. **_____ Household Income is Below Minimum Threshold for Filing Income Tax**
   Total Income: _____ Minimum Threshold: _____

Other Circumstances (Charity NOT Approved):

1. **_____ Living in the US Illegally**
2. **_____ Member of a Recognized Indian Tribe**
3. **_____ Religion Opposes Insurance Benefits/Other:_____**

Approvals:

Prepared by: _____ Title: _____ Date: _____

Approved by: _____ Title: _____ Date: _____
(Authority Level, Business Office Director - Balances <$10K)

Approved by: _____ Title: _____ Date: _____
(Authority Level, CFO - Balances >$10K)