MEMORIAL HOSPITAL
And Health Care Center
Sponsored by the Sisters of the Little Company of Mary, Inc.
800 West 9th Street ▲ Jasper, IN 47546 ▲ 812/996-2345
www.mhhcc.org

Summary of Financial Assistance Policy

Memorial Hospital and Health Care Center is a non-profit entity established to meet the health care needs of the citizens of Dubois and surrounding counties. Sponsored by the American Province of the Little Company of Mary Sisters, the Hospital is committed to treat all patients with respect and fairness regardless of their ability to pay. It is understood that a patient's financial status may change over time, and the Hospital will re-establish a patient's eligibility at reasonable intervals sufficient to ensure that the patient remains in financial need.

Who Is Eligible?

Under the Financial Assistance Policy, a patient will qualify for full or partial financial assistance if the patient is not eligible for group health insurance through an employer, and the patient's household income is less than 200% of the Federal Poverty Guidelines, as periodically published in the Federal Register, for the number of people living in the household, or if the patient's household income is between 200% and 400% of the Federal Poverty Guidelines, as periodically published in the Federal Register, for the number of people living in the household. Patients who are eligible for financial assistance will not be charged more for eligible care than the amounts generally billed to patients with insurance coverage. Prior to seeking Financial Assistance under the this Policy, all patients or their guarantors are encouraged to consult with a Patient Resource Claim Aide Advocate to determine if healthcare coverage may be obtained from a government insurance/assistance product or from the Health Insurance Exchange.

What Services Are Covered?

Services eligible for financial assistance are all emergency and medically necessary inpatient and outpatient services wholly owned and offered by the Hospital. Services of Hospital employed physicians and healthcare providers are also eligible for financial assistance. Financial Assistance is not available for elective procedures such as cosmetic, surgical weight loss or experimental procedures (including non-FDA approved devices), specialty replacement lenses, hearing aids, services denied by insurance for no prior authorization or non-emergency services provided as a result of being out-of-network.

How Can I Apply?

To apply for financial assistance, an individual typically must complete a written application. The individual must provide particular supporting documentation, as described in the Financial Assistance Policy and the Financial Assistance Application. Both the policy and application can be downloaded from the Memorial website www.mhhcc.org or can be obtained for free from the Memorial Hospital at the main Registration Desk, the registration area of the Emergency Room, or the Cashier/Financial Counselor Office. The Financial Assistance Application can also be found on the back of your hospital bill/statement. You may request an application by emailing financialassistance@mhhcc.org or by calling 812-996-0413 and should be returned to the Cashier/Financial Counselor Office of Memorial Hospital and Health Care Center.

How Can I Get Help with an Application?

For help with a Financial Assistance Application, you may contact Patient Financial Services Department of Memorial Hospital and Health Care Center at (800) 852-7279 (toll free) or (812) 996-0637 for last names beginning with A-L OR (812) 996-0413 for last names beginning with M-Z. You may also request assistance through email: financialassistance@mhhcc.org.

How Can I Get More Information?

Copies of the Financial Assistance Policy and Financial Assistance Application form can be downloaded from the Memorial website www.mhhcc.org or can be obtained for free from the Memorial Hospital at the main Registration Desk, the registration area of the Emergency Room, or the Cashier/Financial Counselor Office. Request for an application can also be obtained by emailing financialassistance@mhhcc.org or by calling 812-996-0413.
The Financial Assistance Application can also be found on the back of your hospital bill/statement.

What If I Am Not Eligible?

Patients who do not quality for financial assistance under the Financial Assistance Policy may qualify for other types of assistance. For more information, an individual may contact Patient Financial Services Department of Memorial Hospital and Health Care Center at (800) 852-7279 (toll free).

Translations of the Financial Assistance Policy, the Financial Assistance Application, and this plain language summary are available in the following languages upon request: Spanish, Chinese, and German.

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FINANCIAL ASSISTANCE PROGRAM

Enclosed you will find the Memorial Hospital and Health Care Center Financial Assistance application. This application will be used to determine full or partial financial assistance on qualifying bills.

Please complete the financial disclosure and provide supportive documentation to be used to evaluate your request for a financial assistance. Return the *completed* Financial Assistance application within 21 days.

The following information must be submitted with the application:

☐ 1. A letter that includes all circumstances which currently affects your income

☐ 2. Your most recent Federal Tax and W2 forms

☐ 3. Current bank statement

☐ 4. Two - most recent payroll check stubs, even if no longer employed

☐ 5. Proof or a copy of any Social Security, disability and/or pension income

☐ 6. Unemployment income verification, if applicable.

☐ 7. A list of your medical bills – include total amount owed and to whom

☐ 8. Out-of-pocket expense for prescription medications, monthly or yearly

After the information has been received, your application will be reviewed and a determination will be made. Please contact our office in approximately 30 days for the results of the determination.

Thank you for you for your interest in our program.

If you have questions or need further assistance, please contact:
Patient Financial Services Department
Memorial Hospital And Health Care Center
(800) 852-7279 Toll Free
(812) 996-0637 for last names beginning with A-L
(812) 996-0413 for last names beginning with M-Z
Fax (812) 996-8544
financialassistance@mhhcc.org
gdanhafe@mhhcc.org OR rrobinson@mhhcc.org

MEMORIAL HOSPITAL AND HEALTH CARE CENTER
FINANCIAL ASSISTANCE APPLICATION

Full and complete financial disclosure is required in order to evaluate your request for financial assistance. Incomplete or insufficient information will result in a denial of your request.

Name	Date of Birth	SS#
Spouse's Name	Date of Birth	SS#
Address	City	State/Zip Code
Phone Number	Marital Status	Email Address

Dependents and/or members living in your household:

Name/Age	Name/Age
Name/Age	Name/Age
Name/Age	Name/Age
Name/Age	Name/Age

Employer	Phone #
Rate of Pay $ -- Hour/Week/Month	Length of Employment

Spouse's Employer	Phone #
Rate of Pay $ -- Hour/Week/Month	Length of Employment

Group Health Insurance and/or Private Health Insurance: Yes No
If no, explain why no health insurance coverage

Have you applied for Medicaid? Yes No
If you have applied and did not receive, what was the reason?

OTHER INCOME SOURCE	APPLICANT	SPOUSE	OTHER
Social Security	$ per month	$ per month	$ per month
Pension/Retirement Funds	$ per month	$ per month	$ per month
Welfare/Public Assistance	$ per month	$ per month	$ per month
Food Stamps	$ per month	$ per month	$ per month
Unemployment	$ per month	$ per month	$ per month
Child Support	$ per month	$ per month	$ per month
Interest Income/Stock Bond/CD Investments	$ per month	$ per month	$ per month

Bank Name:	Checking Account: $ Savings Account: $
Life Insurance Company Name:	Cash Value: $
Personal Property:	Value: $
Vehicles:	Value: $

Financial Obligations (Monthly):

Rent: $	Mortgage: $	Phone/Basic: $	Cell Phone: $
Electricity: $	Gas/Propane: $	Food: $	Other: $
Insurance: $	Clothing: $	Education: $	Credit Cards: $

Loans (Whom do you owe?):

Financial Institution:	Monthly Payment: $
Financial Institution:	Monthly Payment: $

Other Obligations:
Medical Obligations:

I understand that the information which I submit is subject to verification by Memorial Hospital And Health Care Center. I certify that the above information is true to the best of my knowledge.

Signature of Patient (Responsible Party)	Date:	Phone #: