Marshall Health

# Reduced Cost Services Application

Patient's name: _____ SSN/MRN: _____

Mailing Address: _____ Email: _____

City/State/Zip: _____ Phone Number: _____

Household Size (Number of federally recognized members only of your legal household): _____

**Until your account is on our approved Waiver: Any patient before being seen can (at department discretion) be required to pre-pay any amount normally required for that department's services, which would supersede any current budget plan. Please be advised that any current budget plan payment amount can be increased by Marshall Health discretion if and when the patient account balance also increases.**

## Eligibility Information

Household Gross Income (Any income before deductions for all federally recognized members only of your legal household):

| | Last Three Months | Last Calendar Year | Verification Required |
|---|---|---|---|
| Salary/Income | _____ | _____ | _____ |
| Pension/Disability | _____ | _____ | _____ |
| Public Assistance | _____ | _____ | _____ |
| Child Support | _____ | _____ | _____ |
| Social Security | _____ | _____ | _____ |
| Other Income | _____ | _____ | _____ |
| Sub-total | _____ | _____ | _____ |
| | *x4* | | |
| Projected Total | _____ | _____ | |

*Certification: I certify to the best of my knowledge and belief, and under appropriate penalties of law, that the above information is accurate, current, and complete and I authorized Marshall Health or their agents and employees to verify such information as may be required to consider my application for assistance under the Reduced Cost Services program.*

Applicant signature: _____ Date: _____

## Determination of Eligibility

Request For Financial Assistance Approval At:

- 100% of Approved Charges _____
- *25% of Approved Charges _____
- *50% of Approved Charges _____
- *75% of Approved Charges _____

*(*Above Percentages are Patient Responsibility)*

Request For Assistance Denied Due:

- Incomplete Application _____
- Exceeds Income Guidelines _____
- Other _____

Date of Initial Request: _____

**Determination of eligibility will be made on or before _____ (Date)*

Date of Determination: _____ Financial Counselor Signature _____

**Application automatically expires one (1) year from the date of the approved application*

## FOR RESTRICTIONS AND/OR EXCLUSIONS PLEASE CONTACT THE DEPARTMENT OR FINANCIAL COUNSELOR - LAST REVISION 12/19/16

## Marshall Health Notice of Availability/Application For Reduced Cost Services

It is the policy of the Marshall Health, subject to their respective medical capabilities, financial resources and the guidelines outlined below, to make available appropriate and medically necessary health care services to all individuals without respect to their ability to pay for such services.

Each Department/Division of Marshall Health will determine what services are available under the uncompensated or reduced cost care program. Only medically necessary physician services will be included and laboratory, x-ray or other ancillary services provided by third parties or under contract to Marshall Health will not be included.

To be eligible for reduced cost care, your household income may not exceed certain income guidelines established by the U.S. Department of Health and Human Services. These guidelines are based on family size and are updated annually.

If you believe you are eligible for the services described above, you may complete the application on the back of this notice and return it to: Financial Counselor, Erma Ora Byrd Clinical Center,1249 15th Street, 2nd Floor, Huntington, WV 25701. You may be required to apply for health insurance coverage under the Medicare, Medicaid or other federal and/or state insurance programs if it appears that coverage may be available thereunder. You may also be required to supply copies of pay stubs, W-2 forms, income tax returns and/or other documents necessary to verify your income level. Once a completed application and verification information have been received the Financial Counselor will make a written determination regarding your eligibility under the program and return a copy to you.

Applications will be held pending review for a period of not more than thirty (30) days until required eligibility documentation is received. Questions concerning the operation of this program should be directed to a Financial Counselor in the Department/Division where you are seeking services. Questions, comments and/or concerns regarding operation of this program may also be addressed in writing to C.E.O., Marshall Health. 1600 Medical Center, Suite 3400, Huntington, WV 25701.

| Category A | | Category B | | | | | |
|---|---|---|---|---|---|---|---|
| Free Approved Charges | | Category B Class 1 | | Category B Class 2 | | Category B Class 3 | |
| Size of Family | 125% Poverty Guidelines | Greater Than | Up to 133% PIGs | Greater than | Up to 166% PIGs | Greater Than | Up to 200% PIGS |
| 1 | $18,255 | $18,226 | $19,391 | $19,392 | $24203 | $24,204 | $29,160 |
| 2 | $23,395 | $23,396 | $26,228 | $26,229 | $32,736 | $32,737 | $39,440 |
| 3 | $31,075 | $31,076 | $33,064 | $33,065 | $41,268 | $41,269 | $49,720 |
| 4 | $37,500 | $37,501 | $39,900 | $39,901 | $49,800 | $49,801 | $60,000 |
| 5 | $43,925 | $43,926 | $46,767 | $46,768 | $58,333 | $58,334 | $70,280 |
| 6 | $50,350 | $50,351 | $53,573 | $53,574 | $66,865 | $66,866 | $80,560 |
| 7 | $56,776 | $56,777 | $60,409 | $60,410 | $75,398 | $75,399 | $90,840 |
| 8 | $63,200 | $63,201 | $67,245 | $67,246 | $83,930 | $83,931 | $101,120 |
| Add $5,140 for each family member | | Add $5,140 for each family member | | Add $5,140 for each family member | | Add $5,140 for each family member | |
| Patient Receives 100% Discount of Approved Charges | | 25%* | | 50%* | | 75%* | |
| | | *Patient Share of Approved Discounted Charges | | | | | |