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Wedowee Hospital

Patient Financial Assistance Program Information

As your community healthcare provider, Wedowee Hospital offers financial assistance programs to help patients meet their medically necessary healthcare financial responsibilities. Wedowee Hospital provides Financial Assistance Program to assist uninsured patients and their families with medical bills beyond their ability to pay.

Wedowee Hospital offers financial assistance programs, which may discount a patient's hospital bill up to 100 percent. The program discounts vary based upon the patient's family size and income level.

Wedowee Hospital Financial Assistance Program- Eligibility requirements:

The Financial Assistance program covers payment for medically necessary care for UNINSURED PATIENTS, but does not cover routine co-pays and deductibles for patients having medical insurance coverage. This program also excludes services deemed not medically necessary, such as fertility services. To apply you must:

1. **Complete an application.** Qualification for the Patient Financial Assistance Program requires a completed application which can be obtained by:
    a. Printing the application from the Wedowee Hospital website at www.wedoweehospital.org
    b. Visiting our facility, where the forms are available at all registration areas; or
    c. Calling 256-357-2078 to have a copy mailed directly to your home.

    When the application is complete, you may either hand deliver it to our facility or mail it to the address below.
2. **Meet required income and family size requirements.** Wedowee Hospital uses a sliding scale based on your family size and income level to determine each patient's hospital discount. The family income must be less than 150 percent of the current Federal Poverty Guideline for each family size.

Household Size	150% of FPG	250% of FPG
1	$17,505	$29,175
2	$23,595	$39,325
3	$29,685	$49,475
4	$35,775	$59,625
5	$41,865	$69,775
6	$47,955	$79,925
7	$54,045	$90,075
8	$60,135	$100,225
For each add'l person, add	$4,060	$4,060

3. **Return the completed Financial Assistance application with your supporting documentation within 30 days of receipt.** We will notify you of our financial assistance decision within thirty days of receiving the completed application. Assistance may be denied without a completed application.

If you wish to discuss applying for financial assistance with a financial counselor, obtain a copy of our Financial Assistance policy, obtain a copy of the Billing and Collection policy, obtain a copy of the application or request help to complete the application, please contact Wedowee Hospital Patient Financial Assistance Department at 256-357-2078 or during normal business hours Monday through Friday from 8 a.m. to 4:30 p.m.

Please mail your completed application to: Wedowee Hospital
ATTN: Patient Financial Counselor
209 N. Main Street
Wedowee, AL 36278

**Not all services provided at Wedowee Hospital are covered under this Financial Assistance Policy. Services that are provided by the Emergency Room Physician, Attending Physician, and/or Radiologist are NOT covered by this policy.

Wedowee Hospital
209 N. Main Street
Wedowee, AL 36278

Wedowee Hospital recognizes how unexpected medical situations can affect your finances. We offer a variety of options to assist with your medical bills including assistance for those who are uninsured. To be considered for Wedowee Hospital's assistance programs,

PLEASE COMPLETE THE ENCLOSED APPLICATION AND MAIL WITH COPIES OF THE FOLLOWING INFORMATION:

- **Federal Tax Return (Form 1040)**
- **Income Verification(include all that apply): 3 Current pay stubs, proof of unemployment, worker's compensation, child support, food stamps, rental income, Social Security, Disability, VA Benefits, Pension, Annuities, or any other source of income**
- **3 Recent bank statement (include Checking and Savings)**
- **Other Assets, properties, IRAs, CDs, Stocks and Bonds**

NOTICE-Applications are based on household income. Please include any of the above information that applies to all members of the household.

Wedowee Hospital is required to provide specific documentation to validate your participation in any assistance program. Your immediate attention and timely response is crucial. Incomplete applications will result in denials and that account balance will be the patient's responsibility.

***After the initial review of your financial information, your case may need further documentation/information. **It is vital to the application process that you cooperate with Wedowee Hospital in providing all requested documented as quickly as possible.** ***

You may be contacted by a Wedowee Hospital representative to discuss your application or to obtain additional financial information.

Please mail the application and supporting documents to:

Wedowee Hospital
ATTN: Financial Counselor
209 N Main Street
Wedowee, AL 36278

CONDITIONS FOR FINANCIAL ASSISTANCE

Liens/Third Party Liabilities: Financial assistance does not release nor pardon any amount due or lien filed through the court system in relation to third party liabilities.

Change in Income/Assets: Patients are required to notify the Business Office of any change in income/assets.

Physician/Hospital Relationship: Healthcare professionals performing services in this hospital may be independent contractors and are responsible for their own actions and billing. Wedowee Hospital shall not be liable for their services. This may include the Emergency Room Provider, Attending Provider, and/or Radiologist.

New Hospital Accounts: It is the patient's responsibility to contact our office when new billing statements are received.

Elective Procedures/Medical Necessity: Financial Assistance may not cover elective procedures.

I agree and understand to the terms listed above.

_____ _____

Patient/Responsible Party Date

_____ _____

Responsible Party (if different from the patient) Date

_____ _____

Witness Date

APPLICATION FOR FINANCIAL ASSISTANCE

Application given to patient on: _____

By: _____

Office Use Only
Application Received on ____/____/_____
Application Processed on ____/____/_____
Account #'s
_____/_____/_____
_____/_____/_____

Patient Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____Zip:_____

Phone: _____ SS#_____ Employer: _____

Spouse: _____ SS#:_____Employer:_____

If Patient is a minor:

Father:_____ SS#:_____Employer:_____

Mother:_____SS#:_____Employer:_____

Insurance information:
If you have applied for Medicaid and were rejected, you must present the rejection letter with this application.

Income Summary:

Total number of persons living in the household: _____. Be advised that **ALL** household income is to be considered and documented with this application.

Annual Family income: $_____ Must provide annual income tax documentation.
Unemployment: $_____ Must provide paystub and/or payment letter
Social Security Income: $_____ Must provide paystub and/or payment letter
VA/Disability benefits: $_____ Must provide paystub and/or payment letter

Hospital use only:
Approved / Rejected Date: _____ Approval / Rejection letter sent: Yes/No Date sent:_____

Reason for denial:_____

_____
Financial counselor signature

Please be advised that this application must be returned no later than 30 days from the date it was issued. The Financial assistance program is for Hospital bills only. Provider services such as Physician fees, radiology fees, outsourced labs, etc. will be billed separately by the individual company.

By my signature below, I state that I understand the guidelines of this application and the information given in the application is true, accurate and proven by the documentation I have provided. I authorize Wedowee Hospital to verify my credit, employment history and financial accounts/assets.

Signature: _____ Date: _____

Assets and other income:

Please list any and all additional assets and/or income below:
(Example: saving and checking account information, CD's, rental properties, stocks, second home or vacation properties, etc.)

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By my signature below, I state that I understand the guidelines of this application and the information given in the application is true, accurate and proven by the documentation I have provided. I authorize Wedowee Hospital to verify my credit, employment history and financial accounts/assets.

Signature:_____ Date:_____