



ST. JOSEPH HOSPITAL

Dear Customer,

Thank you for choosing St. Joseph Hospital for your care. We want you to have a pleasant experience.

This Plain Language Summary explains financial assistance programs for St. Joseph Hospital. We offer a Free Care Program.

Who Qualifies?

Free Care and financial assistance discount are for persons or households

- who are New Hampshire residents
- who have income below 200% of poverty level; and
- who either have no insurance or have out-of-pocket expenses after insurance has been applied

How to Apply

To apply for this assistance, submit the following information:

- Copy of valid state ID (driver's license or state-issues photo ID)
- Proof of income for the most recent 3 months (See Financial Assistance application for acceptable documents)
- Denial letter from the Department of Human Services, if applicable
- Completed Financial Assistance application

Rules

If your application is approved, you will receive discounted or free care for 6 or 12 months. If you are admitted as an inpatient or receive inpatient services 30-days or more after we approve your application, you may be requested to reapply. If you were covered by insurance that we did not know about, you will lose your financial assistance and must pay fully for any services that were adjusted.

What Is Covered?

Free Care services

- performed within 240-days before the date on the bill
- performed by providers employed by St. Joseph Hospital and billed by St. Joseph Hospital
- medically necessary (see attached services that are NOT medically necessary)

Note: Financial Assistance does not apply to services by a non-employed provider; unless indicated (such as, but not limited to, radiologists, pathologists, and anesthesiologist)

More Information

Please contact our Financial Counselors at (207) 777-8208 if any of the following are true:

- You have insurance coverage that you did not disclose to us
- You do not qualify for financial assistance but need help
- You wish to set up a payment arrangement

To apply for Financial Assistance, follow the instructions on the attached application.

Sincerely,

Public Benefits Department

207-777-8208



Non-Medically Necessary Services

- *Acupuncture
- *Admission Not Certified by Utilization Review
- *Breast Pump Rental
- *Cardiac Rehab Phase III
- *Cat Scans for Lung Screening
- *Child Birth Class
- *Circumcision
- *Cosmetic Surgery; Breast Reconstruction, Breast Reduction/Mastopexy, Removal of Excess Skin and Subcutaneous Tissue of Abdomen, Skin Tag Removal for Cosmetic Purposes, EVLT (Endovenous Laser Treatment) for Cosmetic Purposes.
- *Gastric Bypass, Gastroplasty, Gastric Banding (unless deemed to be medically necessary)
- *Infertility Services
- *IOP/Intensive Outpatient Patient Behavioral Program(s)
- *Medical Care by Mail, Telephone or Internet
- *Migraine Procedures (unless deemed to be medically necessary)
- *Off-label Procedures (unless deemed to be medically necessary)
- *Pre-certification Denials for Medical Necessity and an Advanced Beneficiary Notice (ABN) is issued
- *Preparation and Duplication of Records, Forms and Reports
- *Private Room(s)
- *Procedures for altered gender
- *Reversal of Sterilization Procedures
- *Services Not Covered by the Primary Insurance/Payer due to Services Not Being Authorized
- *Services that the patient elects under the HIPAA Privacy Act to not have billed to his/her health insurance and instead elects to pay for the services in full. These services may be medically necessary, but would not be eligible for this program when another payer source is available, but the patient elects not to utilize it.
- *Utilization Review denials for medical necessity and a Notice of Non-Coverage is issued
- *Weight Management Program
- *Other; Non-employed provider (unless otherwise noted in policy addendum), Radiologist, Pathologist, Anesthesiologist, and any services not billed by St Mary's Regional Medical Center and Community Clinical Services.

In liability or MVA situations, proof of valid insurance denial or exhaustion of benefits must be provided before claims will be considered for this program.



Financial Assistance Program Application

| | | | |
|--------------------------|--|------------------------|------------|
| Patient Full Name | | Account Number: | |
| Address | | State | Zip |

Family/Household Member Information (Spouse, and biological or legally adopted children under 18 years old.)

| First and Last Name | Relationship to Patient | Date of Birth | Social Security Number | Are you a citizen? Y Or N | List Medical Insurance and ID for each member. If this application is for a motor vehicle accident or workers' compensation, please also list here. |
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Household Income

Proof of gross household income for **3 months prior to signature date of application** is REQUIRED for all family members to include paystubs, benefit award letters, and self-employment ledgers or returns. Sources of income, include, but not limited to, wages, salaries, tips, taxable amount of pension, annuity or IRA distributions, Social Security benefits, VA benefits, unemployment, TANF, General Assistance, child support, alimony, worker's compensations benefits, rental income. For self-employed, provide a copy of the previous year's income tax return, including the Schedule C.

| Household Member/Employer | Last 3 months income | Last 12 months income |
|---------------------------|----------------------|-----------------------|
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If you have no income, explain your living situation (food/shelter/etc.):

By signing below:

I permit the request for proof of income as noted above. I understand that more information may be requested.

I permit the release of any medical, financial, or employment information that relates directly to my health care or to my financial assistance eligibility. This information may be released to any health care providers from whom I and any household members have received health care services or financial assistance. All information provided will remain confidential under HIPAA federal regulations. Any discounts apply to all balances within the approved period for medically necessary services provided by Covenant Health.

If I am approved for Financial Assistance:

- I understand that I will lose the assistance if I have not fully and correctly presented my income, if I have provided any false information, or if I have not disclosed my insurance coverage. If I lose the assistance, I agree to pay the balance on my account. I also agree to pay any legal fees for the collection process.
- I agree to repay any money if I receive other payment for the medical services covered. Such payments may include insurance payments, governmental program programs, and awards from a lawsuit.

I agree to tell Covenant of any changes that could affect my eligibility, including changes to family size, income, and health insurance coverage. If I might qualify for a public assistance program, I will apply to that program and provide Covenant with the proof of application.

Applicant Signature:

Date: