Adventist HealthCare
Home Care Services

PUBLIC DISCLOSURE OF FINANCIAL ASSISTANCE

Adventist Home Health, Inc. ("AHH") will make available to all patients home health care regardless of race, creed, gender, age, sexual orientation, national origin, or financial statuses that are uninsured, underinsured, or have experienced a catastrophic event and lack adequate resources to pay for services. If there is no medical insurance for reimbursement, the patient (or the patient's guarantor, if any) is responsible for payments. However, if the patient or guarantor does not have the ability to pay AHH for services, they may apply for charity care, a sliding fee scale, or attain a time payment plan. Probable eligibility will be decided within two business days of the initial request for these services or an application for Medical Assistance ("Medicaid") or both.

(Full Financial Assistance Policy Continues Below)

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CHARITY FINANCIAL HARDSHIP APPLICATION

I have requested Charity Care for services I will receive or have received from Adventist Home Health. I understand that if I do not fill this form out truthfully, this request will automatically be denied. If my request for Charity Care is approved based on incorrect information, I will be responsible for paying for all services provided by Adventist Home Health.

Please describe why charity services should be granted. (to be completed by Medical Social Worker)

_____

_____

_____

_____

Patient Name: _____ DOB: _____ _____

Spouse Name: _____ DOB: _____ _____

MONTHLY INCOME

Monthly Household Income:	Gross $ _____	Net $ _____
Other Monthly Income:	Gross $ _____	Net $ _____
Total Monthly Income:	Gross $ _____	Net $ _____

MONTHLY EXPENSES

Rent/Mortgage:	_____	Cable:	_____
Other Medical Expenses:	_____	Furniture/Appliance Payment:	_____
Medical Insurance:	_____	Clothing Expenses:	_____
Life Insurance:	_____	Educational Expenses:	_____
Car Payment:	_____	Charitable Donations (church, etc):	_____
Car Insurance:	_____	Subscriptions/Magazines:	_____
Groceries:	_____	Other Expenses:	_____
Utilities:	_____	Telephone:	_____
Other Assets:			

Credit Card 1 Name	_____	Balance	_____	Number	_____
Credit Card 2 Name	_____	Balance	_____	Number	_____
Credit Card 3 Name	_____	Balance	_____	Number	_____

(Please use the back of this form if you need additional space to list other expenses)

Total Monthly Expenses: $

Please attach W2s, tax returns, and returns, recent pay stubs, and/or bank statements, etc.
If you have additional information that may be helpful in our decision, please attach to this form.

Recommendation: _____

_____

MSW Signature: _____ Date: _____

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CHARITY CARE AGREEMENT

Patient Name _____ Discharge Date _____

Adventist Home Health, Inc. ("AHH") will make available to all patients home health care regardless of race, creed, gender, age, sexual orientation, national origin, or financial statuses that are uninsured, underinsured, or have experienced a catastrophic event and lack adequate resources to pay for services. If there is no medical insurance for reimbursement, the patient (or the patient's guarantor, if any) is responsible for payments. However, if the patient or guarantor does not have the ability to pay AHH for services, they may apply for charity care, a sliding fee scale, or attain a time payment plan. Probable eligibility will be decided within two business days of the initial request for these services or an application for Medical Assistance ("Medicaid") or both.

Our short-term goal is to provide services to educate you about your health care needs and how best for you to manage those needs in a home setting. If you are unable to manage your treatment plan alone, you will be required to authorize someone to do this on your behalf.

Patient Acknowledgement:

I understand and agree that in order for AHH to provide home health services, I am responsible for:

1. Learning to manage my care independently or authorizing someone to learn on my behalf.

2. Providing accurate financial information (on an on-going basis) to assist in determining my eligibility for community resources and Charity Care. **Should my financial information prove inaccurate, my care will be billed retroactive for all services provided and for future care.**

3. Completing initial application processes for available community resources.

4. Continuing to follow up with community resources in a timely manner.

5. Agreeing to release information on Medicaid application to AHH.

6. Charity Care will not cover third party liability cases. If litigation is involved, I will be billed retroactive for the services that were provided for free and will be billed for all future services.

I accept responsibility for compliance with the above stated requirements and acknowledge that failure to comply could result in discharge from AHH. If I do not comply and AHH continues to support my care, this in no way affects the right of AHH to discharge me in the event of a subsequent failure on my part to comply with the terms of this agreement.

Date of Authorization	Signature of Patient
Witness/Relationship	Legal Representative if patient is unable to sign/Relationship to Patient
If patient signs by making an "X"	Witness/Relationship

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Addendum 1
2021 Poverty Guidelines / Sliding Scale Table

Family Size	2021 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,880.00	100%	$ 12,880.00	100%	0%
2	$ 17,420.00	100%	$ 17,420.00	100%	0%
3	$ 21,960.00	100%	$ 21,960.00	100%	0%
4	$ 26,500.00	100%	$ 26,500.00	100%	0%
5	$ 31,040.00	100%	$ 31,040.00	100%	0%
6	$ 35,580.00	100%	$ 35,580.00	100%	0%
7	$ 40,120.00	100%	$ 40,120.00	100%	0%
8	$ 44,660.00	100%	$ 44,660.00	100%	0%
Family Size	**2021 Annual Income Limits**	**Income Guideline**	**Annual Income**	**AHC Responsibility**	**Patient Responsibility**
1	$ 12,880.00	200%	$ 25,760.00	100%	0%
2	$ 17,420.00	200%	$ 34,840.00	100%	0%
3	$ 21,960.00	200%	$ 43,920.00	100%	0%
4	$ 26,500.00	200%	$ 53,000.00	100%	0%
5	$ 31,040.00	200%	$ 62,080.00	100%	0%
6	$ 35,580.00	200%	$ 71,160.00	100%	0%
7	$ 40,120.00	200%	$ 80,240.00	100%	0%
8	$ 44,660.00	200%	$ 89,320.00	100%	0%
Family Size	**2021 Annual Income Limits**	**Income Guideline**	**Annual Income**	**AHC Responsibility**	**Patient Responsibility**
1	$ 12,880.00	225%	$ 28,980.00	80%	20%
2	$ 17,420.00	225%	$ 39,195.00	80%	20%
3	$ 21,960.00	225%	$ 49,410.00	80%	20%
4	$ 26,500.00	225%	$ 59,625.00	80%	20%
5	$ 31,040.00	225%	$ 69,840.00	80%	20%
6	$ 35,580.00	225%	$ 80,055.00	80%	20%
7	$ 40,120.00	225%	$ 90,270.00	80%	20%
8	$ 44,660.00	225%	$ 100,485.00	80%	20%
Family Size	**2021 Annual Income Limits**	**Income Guideline**	**Annual Income**	**AHC Responsibility**	**Patient Responsibility**
1	$ 12,880.00	250%	$ 32,200.00	60%	40%
2	$ 17,420.00	250%	$ 43,550.00	60%	40%
3	$ 21,960.00	250%	$ 54,900.00	60%	40%
4	$ 26,500.00	250%	$ 66,250.00	60%	40%
5	$ 31,040.00	250%	$ 77,600.00	60%	40%
6	$ 35,580.00	250%	$ 88,950.00	60%	40%
7	$ 40,120.00	250%	$ 100,300.00	60%	40%
8	$ 44,660.00	250%	$ 111,650.00	60%	40%

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Addendum 1 – Continued

2021 Poverty Guidelines / Sliding Scale Table

Family Size	2021 Annual Income Limits	Income Guideline	Annual Income	AHC Responsibility	Patient Responsibility
1	$ 12,880.00	275%	$ 35,420.00	40%	60%
2	$ 17,420.00	275%	$ 47,905.00	40%	60%
3	$ 21,960.00	275%	$ 60,390.00	40%	60%
4	$ 26,500.00	275%	$ 72,875.00	40%	60%
5	$ 31,040.00	275%	$ 85,360.00	40%	60%
6	$ 35,580.00	275%	$ 97,845.00	40%	60%
7	$ 40,120.00	275%	$ 110,330.00	40%	60%
8	$ 44,660.00	275%	$ 122,815.00	40%	60%
Family Size	**2021 Annual Income Limits**	**Income Guideline**	**Annual Income**	**AHC Responsibility**	**Patient Responsibility**
1	$ 12,880.00	300%	$ 38,640.00	20%	80%
2	$ 17,420.00	300%	$ 52,260.00	20%	80%
3	$ 21,960.00	300%	$ 65,880.00	20%	80%
4	$ 26,500.00	300%	$ 79,500.00	20%	80%
5	$ 31,040.00	300%	$ 93,120.00	20%	80%
6	$ 35,580.00	300%	$ 106,740.00	20%	80%
7	$ 40,120.00	300%	$ 120,360.00	20%	80%
8	$ 44,660.00	300%	$ 133,980.00	20%	80%
Family Size	**2021 Annual Income Limits**	**Income Guideline**	**Annual Income**	**AHC Responsibility**	**Patient Responsibility**
1	$ 12,880.00	325%	$ 41,860.00	0%	100%
2	$ 17,420.00	325%	$ 56,615.00	0%	100%
3	$ 21,960.00	325%	$ 71,370.00	0%	100%
4	$ 26,500.00	325%	$ 86,125.00	0%	100%
5	$ 31,040.00	325%	$ 100,880.00	0%	100%
6	$ 35,580.00	325%	$ 115,635.00	0%	100%
7	$ 40,120.00	325%	$ 130,390.00	0%	100%
8	$ 44,660.00	325%	$ 145,145.00	0%	100%

Source:2021 Poverty Guidelines |ASPE (hhs.gov)