South Peninsula Hospital

Patient Financial Services
4300 Bartlett Street
Homer, AK 99603
907-235-8101 ~ fax 907-235-0251

Financial Assistance Qualifications

The mission of South Peninsula Hospital is to provide you with quality medical care regardless of your ability to pay. We can appreciate the dramatic impact unexpected medical bills can have when insurance coverage is not available or is insufficient. We are not able to cover elective or cosmetic procedures with this program. Our application process for assistance requires you to provide a variety of supporting documents to be used in our determination process. Individuals qualifying for financial assistance must meet established criteria.

Financial Assistance qualifications are based on a sliding scale point system, reviewing the patient's income, assets, credit and liabilities.

Types of Financial Assistance: Patients may qualify for one or more of the following financial assistance programs:

1) ***Medicaid Recipient Assistance:*** Patients receiving Medicaid assistance and unable to make their Medicaid co-payment may qualify for financial assistance. Co-payments of $50.00 or less will automatically qualify.

2) ***Full or Partial Financial Assistance:*** Patients whose income level is above 100% of the Alaska Federal Poverty guidelines may receive a full or partial medical bill waiver on a sliding scale. The sliding scale will be based on a point system taking into account income, assets, liabilites and credit. Uninsured patients will also qualify for the 25% self-pay discount.

3) ***Catastrophic Financial Assistance:*** Partial or full medical bill waiver for a patient with qualified catastrophic medical bills in excess of $5,000.
    a. Who has suffered a catastrophic medical event as defined in the policy definitions, and/or,
    b. Does not have the resources, income and assets to pay the bill as determined by the Financial Assistance Committee

Financial Assistance Checklist

Applicant: _____ Co-Applicant _____

Patient Name (if different); _____ Date: _____

Forms to be completed:

☐ 1) Application

Income Verification:

☐ 1) Copy of last year's **income taxes**.

☐ 2) Last 2-months **pay stubs**, SSI, Pension, Child Support
Alimony, Unemployment stubs

☐ 3) Most Recent 3-months of **bank statements** for all accounts.

Other Documentation:

☐ 2) **Birth Certificates** for all dependents not listed on taxes

Please call if you have questions

907-235-0235

Financial Assistance Application

Personal Information

Applicant: _____ Date of Birth: _____

Social Security #: _____ Driver's Lic#: _____

Co-Applicant: _____ Date of Birth: _____

Social Security #: _____ Driver's Lic#: _____

Physical Address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____ How long at this address? _____

City: _____ State: _____ Zip Code: _____

Employment Information:

Applicant Employer/Name of Business: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____

Co-Applicant Employer/Name of Business: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____

List Spouse and Dependents:

Name	Age	Relationship

Income and Expenses

Employment:

Employment income should include Employment, Unemployment Benefits, SSI etc…

Who Recieves the Income?	Type of Payment	Amount	How Often?

Self Employment

Who is Self-Employed	Type of Business	Monthly Income	Seasonal work?

Other Income

Other Income should include Alimony, Child Support, AK PFD, Pension/Retirement, Net Rental Royalties

Who Recieves the Income?	Type of Payment	Amount	How Often?

Expenses: Monthly ONLY:

Rent/Mortgage:		Electricity:	
Home Insurance:		Heat	
Property Taxes:		Phone/Internet:	
Auto/Medical/Life Ins.:		Sewer/Water:	
Credit Card Payments:		Vehicle Loans:	
Other:		Other:	
Other:		Other:	
Other:		Other:	
For "Other" types of Expenses, please enter in the type of expense and the amount.			
SPH Medical Bills: Total Owed:		Prior FAP?	Yes No
Amount of Monthly Payments:		# years paying:	

Assets and Resources

Assets, Resources and Other:

Do you own a house, land, apartment, condo, moblie home, duplex, camper or cabin?

Who Owns the Property	Type of Property Owned	Estimated Value	Amount Owed

Do you own a vehicle, car, truck, motorcycle, boat, snowmachine. Watercraft, aircraft, ATV?

Who Owns the Vehicle?	Vehicle Make, Modle, Year	Amount Still Owed	Estimated Value

Do you have a Checking Acct, Savings Acct, IRA, Retirement Funds, Annuities, Inheritance, Life Insurance Policy, Trust Fund, Stocks/Bonds, Native Corporation Shares etc?

Who Owns the Item?	Type of Item	Where Held	Total Value

Other Assets

Type of Asset	Description of Asset	Amount Still Owed	Estimated Value

Statement Of Circumstances

Applicant: _____ Co-Applicant: _____

Please explain your current circumstances, the cause of the hospital bill, your current financial situation and why you are unable to payfor the visit(s). Please use additional paper if needed.

I would like to apply for financial assistance with South Peninsula Hospital. I understand that it is the expectation of South Peninsula Hospital that patients use all of their available financial resources to pay their medical bills before financial assistance will be considered or granted. The information I have provided in this Application as supporting documents are true and complete. By signing this form, I agree to allow South Peninsula Hospital to verify my employment and credit history for the purposes of determining eligibility for financial assistance. I also authorize all organizations and facilities to release information concerning my credit or financial status to South Peninsula Hospital for the same purpose. I understand that South Peninsula Hospital may require more specific proof of any information on this Financial Assistance Application and supporting documents will be provided upon request. If any information in this Financial Assistance Application and supporting documents is found to be false, misleading or incomplete, my application for assistance will be denied. South Peninsula Hospital reserves the right to re-evaluate and/or reverse any charitable service designation if material information is not disclosed or information was misrepresented or deliberately withheld, or if I (or my heirs) make demands for or file a civil action against a third party for personal injuries or damages (including medical charges/expenses). I understand and agree that any financial assistance granted by South Peninsula Hospital may not be used by me or my legal representatives in any negotiations, settlements or lawsuits for the purpose of enhancing an award of monetary damages. Should this occur, I agree that South Peninsula Hospital has the right to reverse any charitable service designation or pursue full charges. The undersigned agrees that the hospital may file and maintain a hospital lien before or after financial assistance is granted on all potential recovery sources.

_____ _____

Applicant Signature & Date Co-Applicant Signature & Date