



509 West 18th Street
P.O. Box 470
Hermann, MO 65041
(573) 486-2191
Fax (573) 486-3743

Hermann Area District Hospital Charity Adjustment Policy

It is the policy of Hermann Area District Hospital to provide essential healthcare services regardless of a patient's ability to pay. Discounts are offered depending upon household income and size. A sliding fee schedule is used to calculate the discount and is updated annually using federal poverty guidelines. Once approved, the discount applies to balances after insurance payments, if any. This does not apply to accounts in Bad Debt. This policy is not part of any larger governmental plan and is solely based upon Hermann Area District Hospital's financial ability to sustain such adjustments at the time of the request.

DISCOUNT APPLICATION PROCESS

A completed application including required documentation of the home address, household income, and insurance coverage must be on file and approved by the Business Office Director before a discount will be granted. If the applicant appears to be eligible for Medicaid, a written denial of coverage by Medicaid may also be required.

The following information will be required. If information is not available, please explain below.

___Hermann Area District Hospital application completed and signed.

___Copy of the first page of the prior year federal tax return.

___Most recent pay stub shows year-to date income.

___Proof of unemployment, either bank statement or unemployment stub.
Disability notice, if receiving Social Security.

Your application cannot be approved unless we receive all information within 7 days of date given.
Return the form and proof of income to:

Hermann Area District Hospital
P.O. Box 470
Hermann, MO 65041
Attn: Business Office Director

Date given:

FINANCIAL ASSISTANCE APPLICATION

Hermann Area District Hospital
PO Box 470 Hermann, MO 65041
573-486-2191

All lines must be completed before we can consider this application. If supporting documentation is not provided within 7 days, we will proceed with our normal collections process.

Guarantor Information			
Last Name	First Name	MI	Marital Status
Home Address	City, State, Zip		Phone Number
Employer	Occupation		

Spouse/Co-Applicant Information			
Last Name	First Name	MI	Marital Status
Home Address	City, State, Zip		Phone Number
Employer		Occupation	

[illegible]

Please provide gross income details (prior to deductions) for head of household, spouse and dependents over age 18 and attach supporting documentation.

Source of Income	Patient	Spouse	Other	Pay Periods			Yearly Total
Employment				Weekly	Bi-weekly	Monthly	
Self-employment or Farm				Weekly	Bi-weekly	Monthly	
Social Security /Disability				Weekly	Bi-weekly	Monthly	
Pension				Weekly	Bi-weekly	Monthly	
Unemployment				Weekly	Bi-weekly	Monthly	
Child Support / Alimony				Weekly	Bi-weekly	Monthly	
Workers Compensation				Weekly	Bi-weekly	Monthly	
VA Benefits				Weekly	Bi-weekly	Monthly	
Other sources				Weekly	Bi-weekly	Monthly	

Health Coverage

- 1) Do you have any health care coverage? Yes _____ No _____ Name _____
- 2) If you are not covered by Medicaid, have you applied for medical benefits? Yes _____ No _____
- 3) If you were rejected by Medicaid, please explain why. _____

Verification

Please sign and date below by all applicable parties in order to complete processing.

I represent that the information provided is true and accurate to the best of my knowledge. I, as payor and signer of this form; certify to the social security number provided to be my legally assigned number.

Signature of Patient/Guarantor

Social Security Number

Date

I represent that the information provided is true and accurate to the best of my knowledge. I, as payor and signer of this form; certify to the social security number provided to be my legally assigned number.

Signature of Spouse/Guarantor

Social Security Number

Date

Denied

Approved
Date

Business Office Director

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