SISKIN GRANT FUND APPLICATION

PATIENT NAME:______________________________ **DATE:**______________________________

NAME: ______________________________ RELATIONSHIP TO PATIENT: ______________

ADDRESS:______________________________ **PHONE:**______________________________

CITY:______________________ **STATE:** ______________ **ZIP CODE:** ____________

SPOUSE'S NAME: ____

EMPLOYER:______________________________ **TITLE:**__________ **SERVICE:** ____________

HOW LONG AT PRESENT ADDRESS?______________ Total # of Dependents (Include Yourself) ________

SPOUSE'S EMPLOYER:______________________ **TITLE:**__________ **SERVICE:** ____________

ASSETS			
	DESCRIPTION	**BALANCE OWED**	**CASH VALUE**
CHECKING ACCOUNT *(List Bank & Acct #)*			
SAVINGS ACCOUNT *(List Bank & Acct #)*			
HOME OWNERSHIP *(Mortgae/Rent)*			
OTHER REAL ESTATE OWNED			
AUTOMOBILE MAKE AND YEAR			
AUTOMOBILE MAKE AND YEAR			
PERMANENT LIFE INSURANCE			
OTHER *(EXPLAIN)*			
OTHER *(EXPLAIN)*			
	TOTALS		

INCOME*

YOUR GROSS SALARY	$	**PER MONTH**	**TAKE HOME PAY:**	$
SPOUSE'S GROSS SALARY	$	**PER MONTH**	**TAKE HOME PAY:**	$
OTHER INCOME *(ITEMIZE)*	$	**PER MONTH**	**TAKE HOME PAY:**	$
OTHER INCOME *(ITEMIZE)*	$	**PER MONTH**	**TAKE HOME PAY:**	$
EXPLAIN OTHER INCOME				

VERIFICATON IS REQUIRED** ***PLEASE ATTACH LAST INCOME TAX RETURN**, a copy of most recent bank statements and any other documents to show proof of income.**

*******ALL INFORMATION OBTAINED IS CONFIDENTIAL********

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DEBTS*		
*Verification may be required	TOTAL OWED	MONTHLY PAYMENTS
HOUSEHOLD: Mortgage ___ Rent___		
UTILITIES: Electric, Gas, Water		
Telephone		
Food		
AUTOMOBILE: Payments		
Insurance		
CHARGE ACCOUNTS *(List Cards and Store Accts)*:		
LOANS: Finance Company		
Bank		
Credit Union		
MISCELLANEOUS *(Explain)*:		

DO YOU HAVE ANY JUDGEMENTS OR LIEN OUTSTANDING? YES ____ NO_____

I certify that the information on this application is a true and complete statement of facts according to my best knowledge and belief. I understand that falsification or failure to provide complete information requested on this application or failure/void any payment agreement already in effect I understand I will be personally responsible for any charges in excess of the approved grant amount below and for all charges for care received beyond the services or dates of service approved below.

Signed_______________________________ Date_______________

RECOMMENDATION: _______________________________ **DATE:**___________

REVIEWED BY:___________________________________ **DATE:**___________

APPROVED BY:___________________________________ **DATE:**___________

GRANT AMOUNT APPROVED: $

APPROVED FOR THE FOLLOWING SERVICES:_______________________________

APPROVED FOR THE FOLLOWING DATES OF SERVICE: **From:** **To:**

Siskin Hospital for Physical Rehabilitation
Financial Assistance Policy

This policy continues the tradition initiated by Mose and Garrison Siskin of providing accessible physical rehabilitation services to individuals in need of those services. Siskin Hospital makes available financial assistance at no cost or reduced cost to eligible individuals in need of such care. The amount of financial assistance is determined during the annual budgeting process. Eligibility is determined by using the federal poverty guidelines (FPG) using a sliding scale of total household income.

Applicable Providers

This policy applies to the following providers which may provide medically necessary care and is not applicable to professional fees (including physicians), unless such fees are for services performed by therapists and psychologists employed by Siskin Hospital. The applicable providers may be known as any of the following:

Siskin Hospital for Physical Rehabilitation
Siskin Subacute
Siskin West
Siskin Hospital Therapy Services

Medically necessary services provided by the above-listed providers are eligible for financial assistance.

Financial Assistance Availability

Financial assistance may be available after all other available resources have been determined. Patients/guarantors must cooperate with the hospital to apply for other existing financial resources that may be available, such as Medicare, Medicaid, TennCare, third party liability, etc. In addition, the patient/guarantor must provide the hospital with financial and other information needed to determine eligibility.

Individuals needing assistance may be identified by the referring or attending physician, referring case manager, admissions staff, clinical personnel, case management, patient accounts personnel, or a member of administration.

Eligibility Requirements

Financial assistance will generally be based upon a patient's household income and determined by a sliding scale based on the federal poverty guidelines (FPG). Individuals with an income level up to and including 200% of the FPG receive medically necessary care at no charge. Individuals with income levels from 201-250% FPG, 251-300% FPG, 301-350% FPG, and 351-400% FPG may receive discounted care based on a sliding scale as set forth below, with discounts ranging from 20% - 80%. Liquid assets available, future income potential, and extenuating circumstances will be considered in measuring household income.

Application Process

Complete and sign the Siskin Grant Fund Application and return along with required supporting documents. We will review your income and family size to determine the level of assistance available based on the sliding scale. We will contact you with any questions and/or requests for additional information and to tell you whether you are eligible for financial assistance under our policy.

Basis for Calculating Amounts Charged

If a patient is eligible for financial assistance, the amount payable by the patient will be determined by the sliding fee schedule shown below. Eligible applicants will be approved for one of the following levels of assistance:

> Free care (100% discount) – The charges for all services provided by the applicable providers listed above will be fully covered by Siskin Hospital, and there will be no amounts payable by the patient to Siskin Hospital.
>
> Discounted Care -- Discounts will be determined based upon the sliding scale discount percentage for the patient's household income per the FPG for applicable family size.

The sliding scale is as follows:

Income Level based on Federal Poverty Guidelines (FPG)	Discount
0-200%	100%
201-250%	80%
251-300%	60%
301-350%	40%
351-400%	20%

In addition, patients whose overall monthly debts exceed net monthly income by more than 10% may be approved for a full waiver of self pay balances. Siskin Hospital will also consider extenuating circumstances including likelihood of the patient's future earnings being sufficient to meet obligations as well as prior determinations under this policy for a patient.

Persons eligible for financial assistance will not be charged more for medical necessary care than amounts generally billed to individuals who have insurance covering such care.

Collection Methods

Self pay accounts will not be subject to bad debt collection actions within 120 days of initial self pay statement. Efforts will be made to inform patients of available financial assistance. Siskin Hospital's contracted self pay agency will provide financial assistance applications to patients following communication with patients regarding status of account. If a patient applies for financial assistance, a decision will be made on the application and communicated to the patient; collection activities will not occur during the time an application is pending.

If a financial assistance application is denied, the patient/guarantor must resolve the outstanding balance or collection actions will be pursued which include referral to bad debt collection and reporting to credit bureaus.

Siskin Hospital for Physical Rehabilitation
Financial Assistance Policy
Plain Language Summary

Siskin Hospital makes available financial assistance at no cost or reduced cost to eligible individuals in need of physical rehabilitation services. Eligibility is determined by using the federal poverty guidelines (FPG) using a sliding scale of total household income and family size.

This document is a summary of the policy.

Eligibility Requirements

Financial assistance is available for both uninsured and underinsured patients and is determined based upon sources of payment identified (insurance coverage and other sources), household income, family size, assets, and other factors. Applicants must cooperate with the hospital to provide the information and documentation necessary to determine eligibility for assistance and/or apply for other available resources to cover the cost of care.

How to Apply/Contact Information

The Siskin Grant Fund Application must be completed, signed, and submitted along with supporting documentation. A free copy of the application can be obtained as follows:

- Visit the hospital's website at www.siskinrehab.org
- Call Patient Accounting at 423-634-1577 to request a copy by mail
- Visit Patient Accounting at 1 Siskin Plaza, Chattanooga, Tennessee

Assistance

Please contact Patient Accounting at the above phone number or address for assistance with the application process or any questions regarding the policy or application.

The Financial Assistance Policy, Plain Language Summary, and Siskin Grant Fund Application can be furnished by Siskin Hospital, at no charge to patients, in other languages through use of translation aids, translation guides, or qualified bilingual interpreters for patients served by Siskin Hospital who have limited proficiency in English.

Amounts Charged

An individual eligible for financial assistance will not be charged more than the amounts generally billed for medically necessary care to patients who have insurance for such care.