BROOKS Rehabilitation

# 2021 – Internal Use Only

## Outpatient Initial Financial Assistance Request

| **Date of Request:** | **Clinic: (Required)** | **TO#:** |
|---|---|---|
| **Patient Name:** | | |
| **Diagnosis (Orthopedic or Neurological):** ***********No Financial Assistance can be granted until Deductibles are met************* | | |

**Services (Check all that apply):**

☐ **PT** ☐ **OT** ☐ **ST** ☐ **OTHER___ ___**

**Reason for Request (check all that apply):**

☐ **Transportation** ☐ **Co-Pay/Co-Insurance Assist**

☐ **Benefits Exhausted** ☐ **No Coverage** ☐ **FULL Medicaid** (w/ Disclosure Form Instructions page (pg 1) and Medicaid verification)

☐ **Other ________________________________** ☐ **IN to OUT**

## *Disclosure Checklist*

*Please check as information is received.* ***Request cannot be processed without all of the below complete.***

- ☐ Cover page completed by Front Desk Coordinator (pg. 1)
- ☐ Total number in home completed (pg. 3)
- ☐ Household bills grid completed (pg.4)
- ☐ Signed by the patient/parent **&** the spouse (pg 2, 4 and 5).
- ☐ Guidelines sheet signed and witnessed (pg. 5).
- ☐ Proof of Income (additional attachment)

***Proof of income is required for ALL individuals living in the home. A minimum of ONE of the following listed below is REQUIRED****. Additional information may be requested upon review of the account. Please circle all included.*

| Recent 3 – Work Check Stubs | Recent 3 – Bank (Checking) Statements | **SSI/Disability** |
|---|---|---|
| **2020 W2 Forms** | **2020 Tax Returns** | Unemployment |
| | Medicaid | SS.Gov |

### *For Approval Use Only*

**Please review spreadsheet for details on patients approval, status and visits**

| ***Circle one:*** | *Approved* | *Pending* | *Denied* |
|---|---|---|---|
| **Additional comments:** | | | |
| **Brooks FA Cost Share Amt:** | | **# Visits approved:** | |
| ***FA Dept Review:*** | | | |

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# Financial Assistance Approval Notification

Date: ________________________

Patient Name_____________________ Acct #______________________

We have completed the review of your financial assistance application. Based on the information provided you have been approved for full financial assistance for services provided by Brooks Rehabilitation. This means that you will not be responsible for any charges associated with the services provided by Brooks Rehabilitation under this approval.
The services that have been approved are outlined in the table below.

| Care Setting | Brooks Rehabilitation Services | Approved Date Range | Number of visits/LOS |
|---|---|---|---|
| ☐ Inpatient Hospital | All services provided by Brooks Rehabilitation | | |
| ☐ Outpatient | Physical Therapy (PT)<br>Occupational Therapy (OT)<br>Speech Therapy (ST)<br>Other _____________ | | PT ___________<br>OT____________<br>ST____________<br>Other __________ |
| ☐ Brooks Medical Group | Physician Services | | |
| ☐ Skilled Nursing Facilty | All services provided by Brooks Rehabilitation | | |
| ☐ Home Health | Skilled Nursing<br>Physical Therapy<br>Occupational Therapy<br>Speech Therapy<br>Social Worker<br>Home Health Aide<br>Respiratory Therapy<br>Other_______________ | | |

BROOKS REHABILITATION

*A Member of the Brooks Health System*

**Patient Financial Disclosure Instructions**

# Welcome & Thank You for Choosing Brooks

Dear Patient:

Attached is a Financial Disclosure that will help us determine if you are eligible for financial assistance.

Brooks Rehabilitation bases your eligibility for this program on the State of Florida Agency for Healthcare Administration (AHCA). (See Enclosed Form).

This program is designed to help patients who have little or no health insurance.

If you are interested in applying for assistance, please complete this form, attach your proof of income, and return to your Brooks Rehabilitation Representative.

Upon receipt of all required information, we will review for eligibility and notify you of the determination. Brooks Rehabilitation agrees to hold confidential all information submitted in this application and agrees it shall be used only for the contemplated purposes, and shall not be used for any other purpose, or disclosed to any third party.

**We cannot process your application for financial assistance without the following information:**

- **Signed Request for Uncompensated Services (Guideline Letter) (Page 5)**
- *** Proof of HOUSEHOLD income**
  **(all people over 18 , who earn income and live in the house)**
- **Completed Financial Disclosure Form (Page 3 & 4)**

If you have any questions, please feel free to contact the Business Office at the number listed below.

Sincerely,

| **Inpatient** | **Outpatient** | **Physician** | **Home Health** | **Bartram SNF** | **University SNF** |
|---|---|---|---|---|---|
| Business Office | Business Office | Business Office | Business Office | Business Office | Business Office |
| (904) 345-7630 | (904) 345-7251 | (904) 345-7373 | (904) 306-9729 | (904) 528-3017 | (904) 345-8326 |

BROOKS Rehabilitation

**Brooks Financial Assistance** **Disclosure Form Instructions**

Dear Patient:

Brooks Financial Assistance program is designed to help patients who have little or no health insurance to cover the cost of their rehabilitation. Services rendered under the Financial Assistance program are short term solutions to bridge the gap between insurance and the patient's needs. It is not intended to support long term care and is provided as the last option.

Brooks determines your eligibility for this program based on medical necessity and on financial need*. The Brooks Financial Assistance disclosure form will help us determine if you are eligible for aid from Brooks and the amount you are eligible to receive. All information you submit is confidential and will be used for this purpose only. It will not be shared with any outside party.

Please complete the attached form and return the application and copies of proof of income (identified on the application form) to your Brooks Rehabilitation representative where you are being treated. The sooner you submit your completed application, the sooner we will be able to process the information and determine eligibility. Please remember that you will be responsible for all payments prior to determination of Brooks Financial Aid eligibility, so it is to your advantage to submit the completed forms as soon as possible.

**Patient Responsibility if Approved for Brooks Financial Assistance**:

- If you are required to pay some amount toward your rehabilitation you will be asked to pay for your portion prior to or at the time of service.
- You must contact us ASAP if you cannot make a scheduled appointment. If you do not contact us and/or cancel two times, you will be discharged immediately.
- You must continue to meet medical necessity requirements throughout their rehabilitation program. This means that the patient is making significant progress in a reasonable period of time. The financial assistance committee periodically reviews patients' progress to determine if they are showing improvement. If a patient's therapy progress has slowed or reached a plateau they may be discharged from the Brooks Financial Assistance program.
- You must inform us if your income or insurance changes during treatment or if similar services can now be received in the school or at another type of facility. You may be asked to fill out a new application which will be reviewed by the financial assistance committee.
- No services will be covered under Financial Assistance for Non-US Citizens.
- OP Only: If you are 21 years of age or older, you will be asked to submit a new application every 3 months. If you or your dependents are under 21, you will be asked to submit a new application every 6 months.
- **Please be aware that if you are in the legal process of obtaining a settlement for an automobile accident or other claim then Brooks will file a lien with your Attorney for services to be paid upon settlement. Please provide your Attorney's Name and Phone Number:** ______________________________________________.

Please allow one week for processing of your application. If you have any questions, please feel free to contact your Brooks Rehabilitation Representative or call our customer service line at (904) 345-7251.

**Signature:** ________________________________ **Date:** ___________________________

BROOKS Rehabilitation



## PERSONAL INFORMATION

**Patient's Name** ______________________________________________

Home Address ______________________________________________

Social Security # ____________________ D.O.B. ____________ Age ______________

Home Phone ____________________________ Cell Phn __________________________

Circle One: Actively Employed Retired Disabled Unemployed

Employer ______________________ Length of Employment ______________________

Employer Addr. ______________________________________________

Business Phone ______________________ Occupation ______________________________

Hourly Wage ______________________

Total Monthly Income ______________________ (submit ALL proof of income)

All Other Income (Gross) ______________________ (submit proof Alimony/Child Support, Etc.)

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**Parent/Spouse Name** ______________________________________________

Home Address ______________________________________________

Social Security # ____________________ D.O.B. ____________ Age ______________

Home Phone ____________________________ Cell __________________________

Circle One: Actively Employed Retired Disabled Unemployed

Employer ______________________ Length of Employment ______________________

Employer Addr. ______________________________________________

Business Phone ______________________ Occupation ______________________________

Hourly Wage ______________________

Total Monthly Income ______________________ (submit ALL proof of income)

All Other Income (Gross) ______________________ (submit proof Alimony/Child Support, Etc.)

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## HOUSEHOLD INFORMATION

**Please list any and all individuals living in your home (including patient)**

Name ______________________ Relationship ______________ Age _____ Employed? ____

Name ______________________ Relationship ______________ Age _____ Employed? ____

Name ______________________ Relationship ______________ Age _____ Employed? ____

Name ______________________ Relationship ______________ Age _____ Employed? ____

Name ______________________ Relationship ______________ Age _____ Employed? ____

Name ______________________ Relationship ______________ Age _____ Employed? ____

**Total Number in Household** ______________________

*****Applications cannot be approved without proof of income and signatures.*****

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**Patient Name:** ______________________
**Location:** __________________________

## GENERAL ASSESSMENT INFORMATION

**Circle one answer for each of the following questions:**

1. Marital Status: Married Separated Divorced Single Other ______________________
2. Do you have insurance? No Yes ______________________________________
3. Are you eligible for Cobra or insurance benefits from employer? No Yes ________________
4. Have you applied for Medicaid? No Yes When? ________________________________
5. Do you have any pending lawsuits? No Yes ______________________________________
6. If YES to # 5, please provide your Attorney's Name & Phone Number:

   ______________________________________________________________________________
7. Have you received any settlements? No Yes ______________________________________
8. Are you a natural born citizen? No Yes ______________________________________
9. Where were you born? ______________________________________________________
10. Are you a US Citizen? No Yes
11. Do you have valid Work/Student Visa No Yes
12. Do you own home? No Yes Approx. Value __________________________
13. Are you renting? No Yes How Long? __________________________
14. Do you own other property? No Yes Approx. Value __________________________
15. ***Please include a copy of state issued picture identification with your application.***

## HOUSEHOLD CREDIT/EXPENSE INFORMATION

| List All Debt Owed | Company Name | Total/Present Balance | Monthly Payment |
|---|---|---|---|
| Mortgage/Rent | | | |
| Car Payment | | | |
| Credit Card | | | |
| Credit Card | | | |
| Food | | | |
| Electric | | | |
| Phone | | | |
| Prescription/Medicines | | | |
| Cable | | | |
| Other | | | |

"The undersigned hereby acknowledges the information provided in this financial statement to be true and correct to the best of my (our) knowledge. By signing this financial statement, I (we) hereby authorize to inquire into my (our) credit history and to contact my (our) employer(s) for verification of income. I (we) further authorize my (our) employer(s) to supply to Brooks Rehabilitation information verifying my (our) income, upon presentation by Brooks Rehabilitation of a copy of this financial statement."

______________________________________ ______________________________________
Patient or Responsible Party Signature Guarantor/Spouse's Signature

BROOKS℠ Rehabilitation

*Patient Name:* ______________________
*Location:* __________________________

# Request for Determination of Eligibility for Uncompensated Services

I, herein, request that Brooks Rehabilitation make a determination of my eligibility for uncompensated services. I understand that the information I submit is subject to verification.

Eligibility is based on the State of Florida Agency for Health Care Administration (AHCA) guidelines as follows:

> No patient will be considered a charity/uncompensated care patient whose family income as applicable for the twelve (12) months preceding the determination exceeds two hundred (200) percent of the current federal poverty guidelines (below) unless the amount of the charge due from the patient exceeds twenty-five (25) percent of the annual family income. However, in no case shall the charges for a patient whose family income exceeds four (4) times the federal poverty level for a family of four (4) be considered charity.

**2021 FEDERAL POVERTY GUIDELINES**

| Federal Poverty Guidelines | | One or More Must Be Provided to Support This Request |
|---|---|---|
| Family Size | 2021 Federal Income Guidelines | 1) **Income Tax Returns** ( Prior year signed, completed, tax returns for entire household) |
| 1 | $12,880 | |
| 2 | $17,420 | |
| 3 | $21,960 | |
| 4 | $26,500 | 2) **W-2 withholding forms** (Most recent W2 forms for entire household) |
| 5 | $31,040 | |
| 6 | $35,580 | |
| 7 | $40,120 | ***********Proof of income is required for all members of household ********** |
| 8 | $44,660 | |
| Federal Guidelines for each additional person, add $4,540 | | |

I hereby certify that I qualify for the uncompensated service based upon the AHCA guidelines listed above.

Date ______________________________________________

Signature__________________________________________

Witness ___________________________________________

** Florida State Statute 817.50 – Fraudulently obtaining goods, services, etc. from hospital – (1) whoever shall, willfully and with intent to defraud, obtain or attempt to obtain, goods, products, merchandise or services from any hospital in this state shall be guilty of a misdemeanor of the second degree, punishable as provided in SS775.082 or SS775.083.