BROOKS Rehabilitation

2021 – Internal Use Only

In-patient Hospital Financial Assistance Request

Date of Request:	Patient Name: **Last, First M.**
Has the patient applied for Medicaid?	☐ No *If No, Admit as F.ICHARITY ☐ Yes *If Yes, Admit as F.MCDPEN

Reasons for request (check all that apply)

☐ No Insurance	☐ Full Medicaid	☐ Benefits Exhausted
☐ Medicaid Pending	☐ Share of Cost	☐ Other: _____

Financial Disclosure Checklist:

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

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

Completed by: Choose your name.

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 application.

*******Please circle all included******

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

For Approval Use Only

Circle one:	*Approved*	*Pending*	*Denied*
Additional comments:			
Approved by:			
If approved, How?	☐Annual income for family of ____falls below poverty guidelines. ☐Patient balance will exceed 25% of annual income.		

BROOKS Rehabilitation

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) Occupational Therapy (OT) Speech Therapy (ST) Other _____		PT _____ OT_____ ST_____ Other _____
☐ Brooks Medical Group	Physician Services		
☐ Skilled Nursing Facilty	All services provided by Brooks Rehabilitation		
☐ Home Health	Skilled Nursing Physical Therapy Occupational Therapy Speech Therapy Social Worker Home Health Aide Respiratory Therapy 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 <u>HOUSEHOLD</u> 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:** _____

*In order to determine your financial eligibility, we use the State of Florida Agency for Healthcare Administration (ACHA) and for Georgia patients, the Georgia Department of Community Health (GDCH), Division of Health Planning.

BROOKS Rehabilitation

Financial Assistance Assessment

Patient Name: _____

Location: _____

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.)

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.)

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.*****

BROOKS Rehabilitation

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) 2) **W-2 withholding forms** (Most recent W2 forms for entire household) ************Proof of income is required for all members of household ************
1	$12,880	
2	$17,420	
3	$21,960	
4	$26,500	
5	$31,040	
6	$35,580	
7	$40,120	
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.