I. Description

Policy and procedures for providing patient financial assistance programs for services rendered to patients of Rush Foundation Hospital (RFH), all Critical Access Hospitals, provider based clinics and Specialty Hospital of Meridian (SHM). Each of these entities hereafter will be referred to as Rush Health Systems.

II. Rationale

As part of its mission, the Rush Health Systems focuses on making healthcare as accessible as possible for the citizens of East Central Mississippi and West Alabama through its system of hospitals. The purpose of this policy is to use financial assistance resources available to Rush Health Systems to maximize the availability of health care services to the people of East Central Mississippi and West Alabama in a consistent, equitable and effective manner. The policy carefully considers Rush Health Systems’ medical mission to provide care to Mississippi and Alabama residents, emphasizing Rush Foundation Hospital’s role as a provider of specialized services. This policy does not affect or limit Rush Health Systems dedication and obligation under EMTALA to treat, without discrimination, patients with emergency medical conditions, regardless of eligibility under this financial assistance policy. Five guiding principles used in the creation of this policy were the desire to (i) create a consistent policy for the Rush Health Systems; (ii) promote equity in financial responsibility; (iii) simplify administration of care and minimize administrative costs; (iv) use the limited financial resources of the health care system most effectively; and (v) ensure that treatment for illnesses requiring care is provided to Mississippi and Alabama residents. All communication with patients concerning their financial responsibility will be handled with empathy, care and concern while maintaining the financial viability of the system.

III. Notification

Rush Health Systems will post signage in all registration areas to notify all patients of this Financial Assistance policy and the possibility to qualify for assistance. A copy of the policy is available upon request. This policy will also be placed on the systems website to allow access to the general public.

IV. Policy

Rush Health Systems shall have an organized patient financial assistance program designed to help provide necessary health care for East Central Mississippi and West Alabama residents to the extent that resources are available. Notices regarding the availability of patient financial assistance shall be widely posted in patient registration areas at Rush Health Systems facility locations, on Rush Health System’s website, in the Emergency Department(s), and in such other locations as deemed appropriate from time to time by Administration. These notices will be substantially in the form attached as Appendix A hereto.

Rush Health System's patient financial assistance program consists of the following components:

1. Patient Payment Expectations and Requirements
2. Financial Assistance
A. Patient Payment Expectations and Requirements

Patients with the ability to pay are expected to pay for their health care, including the requested copay, any coinsurance, deductible, and for some services, a deposit, at the time of service. When necessary, patients are expected to participate in and adhere to interest-free payment plans for prior, current or future services. Regardless of their insurance status, patients without the ability to pay for some or all of their care are expected to request financial assistance or make their inability to pay known to Rush Health Systems so that their financial status can be verified with a financial counselor and so that they may be evaluated for Financial Assistance pursuant to this policy as posted in all registration areas.

B. Financial Assistance

Financial Assistance is a benefit for Mississippi and Alabama residents (for patients we serve) where, except for specific and limited copayment expectations, the limitations in the Financial Assistance Exceptions Table (Appendix B), and those balances covered by external funding sources, up to 100% of the patient’s balance will be written off as charity. Any resident of Mississippi or Alabama may apply for Financial Assistance, and all applications will be considered without regard to race, color, gender, national origin or religious preference.

1. Eligible Persons and Exclusions. Financial Assistance is available for Mississippi or Alabama residents who meet family income criteria described below and in Appendix F and have a provider referral to Rush Health Systems, for the desired service. A provider referral is not required if the patient is receiving emergency care at Rush Health Systems.
   a. Mississippi or Alabama residency is established either by producing the documentation in Appendix E-1 or by signing the residency declaration substantially in the form of Appendix E-2 or E-3 respectively.
   b. If the patient’s household income is less than or equal to 200% of the current Federal Poverty Guidelines for the patient’s family size, then the patient meets the income criteria for Financial Assistance. Financial counselors will be provided with current information regarding Federal Poverty Guidelines so that they may accurately determine financial eligibility under this policy. Guidelines substantially in the form of Appendix F shall be used to assess any third party coverage and to determine annual household income.
   c. Request for financial assistance from residents outside of Mississippi and Alabama will be considered on a case by case basis.
   d. Financial Assistance is not available for international patients. An international patient is defined as one who resides in a foreign country and is either visiting the United States for tourism or medical/tourism purposes.
   e. Request for financial assistance from patients requiring psychiatric services will be considered on a case by case basis with consideration given to the recommendation of the case worker.

2. Application Process. A Financial Assistance application substantially in the form of Appendix G will be provided to anyone who meets eligibility screening criteria as outlined on The Financial Assistance Screening Tool (Appendix D), to anyone who requests a Financial Assistance application or requests to be evaluated for Financial Assistance, and to anyone who is referred to a financial counselor or Business Services for evaluation of eligibility for Financial Assistance.

3. Application Completion and Review.
   a. Due to the desire to provide services to the patient in a timely fashion or anytime during the collections process, patient applications for Financial Assistance must be received by Rush Health Systems, 30 days from the date the application is mailed to the patient.
b. For patients actively receiving Medicaid or Alacaid, except for family planning and out-of-network Mississippi CAN participants a complete Financial Assistance application is one that has the guarantor and a dependent section completed, bears the patient’s signature, and is supported with a copy of the patient’s valid Medicaid or Alacaid card. For Medicaid or Alacaid patients completing this process, the Financial Assistance eligibility date will be the effective date on the Medicaid or Alacaid card.

c. Once complete and submitted, an application will be reviewed by Rush Health Systems, within 15 business days against Rush Health Systems Financial Assistance eligibility criteria.

d. This review will examine each applicant’s total resources, which could include, but are not limited to, an analysis of assets, liabilities, income and expenses, and any extenuating circumstances that would affect a determination of indigence. Rush Health Systems will use reasonable efforts to document the method by which a determination of indigence is made and will include all backup information to substantiate the determination.

e. A patient, who is a student in either full or part-time status, regardless of employment status, and under the age of 26, is required to submit information regarding parental support and insurance coverage availability as part of the patient’s Financial Assistance application.

f. If additional information is required to reach a determination, then a request for additional information will be sent to the patient and must be returned within 15 days.

g. If a patient’s income or family size changes, a new Financial Assistance application should be submitted with supporting documentation for re-evaluation of Financial Assistance status.

4. Eligible Charges/Services and Exclusions.

a. Financial Assistance covers all medically necessary services pertaining to the approved episode of care except those included in the Financial Assistance Exceptions Table (Appendix B). Medical necessity will be determined by the treating provider. In instances where medical necessity is unclear, Administration will make a final determination.

b. Financial Assistance is available for all the specific episodes of care for which the patient was referred to Rush Health Systems or for which the patient received emergency treatment. Charges for Financial Assistance services will not be changed to zero balance until authorization is given that the service rendered has been approved for financial assistance.

c. Patients approved for Financial Assistance will be required to pay the balance after the approved discount amount has been applied to the account for each encounter or to have arrangements made with Business Services for those accounts. (See Appendix C). Failure to pay on discounted balances pursuant to payment terms and agreements may result in future denials of applications for Financial Assistance until such balances or payments are received.

d. Any payments made to Rush Health Systems, will be counted toward the amount due and will not be refunded.

e. Medicaid patients who have exhausted their Medicaid benefits are automatically eligible for financial assistance for any services rendered on an inpatient and emergency basis.
5. Financial Counseling and Timing of Application. Where possible, a patient requesting Financial Assistance should undergo the financial counseling process prior to the patient's first appointment at any Rush Health Systems, facility. In the financial counseling process, the patient will be screened for eligibility to receive multiple sources of potential payment, including Financial Assistance, in advance of treatment.

a. Nevertheless, for cases involving services for the treatment of emergency services and services for treatment where life or limb-threatening intervention is needed, the patient’s appointment will not be delayed because the patient has not undergone financial counseling. In these cases, the patient is expected to undergo financial counseling as soon as reasonably possible.

b. Similarly, if the provision of care is believed to be medically urgent, the treating provider may request that the patient be allowed to bypass the financial counseling process prior to appointment by making such request to the Director of Business Services or designee. In this case, the patient must complete the financial counseling process as soon as is reasonably possible.

6. Length of Eligibility. A determination of eligibility for Financial Assistance will be effective for 6 months and will apply toward the services previously received as part of the episode of care.

a. The determination of eligibility documents that the patient is eligible for Financial Assistance and prevents the patient from needing to resubmit application documents again within that 6-month period of time.

b. The determination of eligibility does not guarantee the patient the ability to be scheduled for an appointment in any service area while within that 6-month period.

7. Appeals of Denied Applications. The internal referring provider on behalf of the patient or the patient with additional documentation has the right to appeal a denied application for Financial Assistance. The appeal will be reviewed by Administration. Appeals should be directed first to the Director of Business Services or designee and then will be forwarded to Administration for final comment.

8. Changes to the Policy or Eligibility Criteria. Financial Assistance eligibility criteria will be reviewed every 12 months by Administration and will be updated annually to reflect published changes in the Federal Poverty Guidelines. Revisions may be made at any time to the criteria or the policy based on changes in Rush Health Systems’, financial ability to provide financial assistance or changes in state or federal regulations.
Notice to our patients:

Rush Health Systems offers financial assistance to individuals who qualify.

If you think you may qualify, please inquire at registration.
# Appendix B

## Financial Assistance Exceptions Table*

<table>
<thead>
<tr>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cosmetic surgery /procedures**</td>
</tr>
<tr>
<td>Non-medically necessary obstetric ultrasound</td>
</tr>
<tr>
<td>Optical Shop products</td>
</tr>
<tr>
<td>Routine eye exams</td>
</tr>
<tr>
<td>Contact lenses or exams*</td>
</tr>
<tr>
<td>Hearing aids</td>
</tr>
<tr>
<td>Acupuncture</td>
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<tr>
<td><strong>Non-medically necessary virtual colonoscopy</strong></td>
</tr>
<tr>
<td>Non-medically necessary full body MRI</td>
</tr>
<tr>
<td><strong>Routine Dental Care</strong></td>
</tr>
<tr>
<td>Prosthetics or orthotics provided in an outpatient setting</td>
</tr>
<tr>
<td>Gastric stimulator (GES)</td>
</tr>
<tr>
<td><strong>Sleep Studies</strong></td>
</tr>
<tr>
<td>Any retail products</td>
</tr>
</tbody>
</table>

*This list is subject to change per the approval of Administration.

**Cosmetic surgery is not eligible for a payment plan. Full payment required prior to service.
Appendix C
Financial Assistance Guidelines

Payments are due at the time of service. If the patient has been made aware of eligibility for the Financial Assistance Program then the discount listed below can be applied to a visit immediately as long as the patient provides the approval letter to the front desk. The discount the patient has been approved to receive will be applied to those accounts. If the patient is unable to make pay immediately then the patient should be seen by a financial counselor for assistance and screened to ensure the patient is maintaining any prior payment arrangements made on other outstanding accounts prior to sending the patient on for additional treatments. (In the event of an emergency visit or life threatening visit the patient’s care will take precedence and arrangements made after treatment.)

<table>
<thead>
<tr>
<th>Eligibility</th>
<th>Discounts Applied</th>
</tr>
</thead>
<tbody>
<tr>
<td>150-200% of FPL</td>
<td>74%</td>
</tr>
<tr>
<td>Less than 150% of FPL</td>
<td>100%</td>
</tr>
</tbody>
</table>

Notes:

The discount for patient’s eligibility at the 150-200% level is based on the average Medicare discount for the previous 12 months. This discount percentage will be adjusted annually each January.

All discounts applied per this policy will be treated as a charity discount.

For facilities participating in the National Health Service Corps. (NHSC) Program, the schedule on Appendix C-1 will be applicable.
Appendix C-1

The following Schedule will apply to facilities participating in the National Health Service Corps. (NHSC) Program:

ABILITY TO PAY

Sliding Fee Scale/Discounted Fee Schedule

<table>
<thead>
<tr>
<th>Maximum Annual Income Amounts for each Sliding Fee Percentage Category (expect for 0% discount)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poverty Level *</td>
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<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>Family Size</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>1</td>
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<tr>
<td>2</td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
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<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>For each additional person, add</td>
</tr>
</tbody>
</table>

Note:
* Based on the 2013 HHS Poverty Guidelines
Appendix D

Screening Tool for Financial Assistance

Questions to ask the patient:

1. Are you a Mississippi or Alabama Resident?
2. What is your annual income (before taxes)?
3. How many people live in your home?
4. Do you have a provider referral?
Appendix E-1
Residency Definitions and Documentation

I. MS/AL Residency- In order to meet Mississippi or Alabama state residency requirements to be Medicaid eligible, an individual must be domiciled in Mississippi or Alabama, with the intention to remain here permanently or for an indefinite period or show that he entered Mississippi or Alabama to seek employment or with a job commitment. A person is domiciled in Mississippi or Alabama if Mississippi or Alabama is his fixed, established, or permanent place of residence with the intention to remain there permanently or for an indefinite period.

REQUIREMENT: To verify residency, two documents from two of the categories below need to be provided. This means a document or proof must be from two of the little letters below. Example: An item from c. and d would be acceptable. Two documents in “b” are not acceptable. Applicants who do not have two of the documents must complete and sign the declaration on the back of this form, subject to prosecution, that they do not have two of the documents listed.

a. A valid Mississippi or Alabama driver’s license or other identification card issued by the Mississippi or Alabama Division of Motor Vehicles.

b. A current Mississippi or Alabama rental lease, or mortgage payment receipt, or current utility bill in the name of the applicant or the applicant’s legal spouse, showing a Mississippi or Alabama address.

c. A current Mississippi or Alabama motor vehicle registration in the applicant’s name and showing the applicant’s current Mississippi or Alabama address.

d. A document verifying that the applicant is employed in Mississippi or Alabama.

e. One or more documents proving that the applicant’s home in the applicant’s prior state of residence has ended, such as closing of a bank account, termination or sale of a home.

f. The tax records of the applicant or the applicant’s legal spouse, showing a current Mississippi or Alabama address.

g. A document showing that the applicant has registered with a public or private employment service in Mississippi or Alabama.

h. A document showing that the applicant has enrolled his children in a public or private school or a child care facility located in Mississippi or Alabama.

A document showing that the applicant is receiving public assistance (such as Food Stamps) or other services which require proof of residence in Mississippi.

i. Records from a health department or other health care provider located in Mississippi or Alabama which shows the applicant’s current Mississippi or Alabama address.

j. A written declaration from an individual who has a social, family, or economic relationship with the applicant, and who has personal knowledge of the applicant’s intent to live in Mississippi or Alabama permanently, for an indefinite period of time, or residing in Mississippi in order to seek employment or with a job commitment.

k. A current Mississippi or Alabama voter registration card.

I. A document from the US Department of Veteran’s Affairs, US Military or the US Department of Homeland Security verifying the applicant’s intent to live in Mississippi or Alabama permanently or for an indefinite period of time, or that the applicant is residing in Mississippi or Alabama to seek employment or with a job commitment.

m. Official Mississippi or Alabama school records, signed by school officials, or diplomas issued by Mississippi or Alabama schools (including secondary schools, colleges, universities, community colleges), verifying the applicant’s intent to live in Mississippi or Alabama permanently or for an indefinite period of time, or that the applicant is residing in Mississippi or Alabama to seek employment or with a job commitment.

n. A document issued by the Mexican consular or other foreign consulate verifying the applicant’s intent to live in Mississippi or Alabama permanently or for an indefinite period of time, or that the applicant is residing in Mississippi or Alabama to seek employment or has a job commitment.
Appendix E-2

Form of Mississippi Residency Applicant Declaration

I________verify that I cannot provide two Mississippi state residency verification documents.

I hereby declare that the above information is true and accurate. I understand that this declaration form is used to help verify that I meet Mississippi state residency requirements for the (ENTER ENTITY) Financial Assistance program. I understand that a false or misleading declaration by me may result in financial assistance adjustments and benefits for which I would not otherwise have qualified, and may subject me to civil and criminal penalties.

________________________________________
Signature

________________________________________
Date

Address: ________________
____________________________________
____________________________________
____________________________________

Telephone No. ________________
Appendix E-3

Form of Alabama Residency Applicant Declaration

I ___________verify that I cannot provide two Alabama state residency verification documents.

I hereby declare that the above information is true and accurate. I understand that this declaration form is used to help verify that I meet Alabama state residency requirements for the (ENTER ENTITY) Financial Assistance program. I understand that a false or misleading declaration by me may result in financial assistance adjustments and benefits for which I would not otherwise have qualified, and may subject me to civil and criminal penalties.

Signature

________________________________________

Date

________________________________________

Address : __________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Telephone No. ____________________________
Appendix F

Third-Party Coverage and Annual Income Worksheet

Third-Party Coverage - All patients will be screened for third-party sources of coverage and assistance which may include, but are not limited to:

1) Personal or Employee Sponsored Health Insurance
2) Medicare, Medicaid, CHIP, commercial, or any other third party coverage
3) Eligibility for public assistance programs
4) Third party coverage from an employer or family member’s employer
5) Workers’ Compensation

Patients eligible for third-party sources of coverage may be excluded from receiving Financial Assistance, based on individual circumstances surrounding the patient(s) and the accounts under consideration.

Annual Income/Employment Status Worksheet - Income includes total cash receipts from all sources before taxes. Verification of income is not required for dependents under age 18.

The following are considered income:

1) Wages and salaries before deductions
2) Self-employment income
3) Social security benefits
4) Pensions and retirement income/distribution
5) Unemployment compensation
6) Strike benefits from union funds
7) Workers’ Compensation
8) Veterans’ payments
9) Public Assistance payments
10) Training stipends
11) Alimony
12) Military family allotments
13) Income from dividends, rents, royalties, & interest income
14) Payments from estates and trusts
15) Payments from legal settlements
16) Regular insurance or annuity payments
17) Support from an absent family member or someone not living in the household
18) Lottery winnings
19) One third of liquid assets drawn down as a withdrawal from a bank. The most recent checking and savings account statements from the guarantor are required. Stocks, bonds and non-retirement investments are considered available liquid assets to be used for this calculation. Long-term retirement annuities are not included when considering liquid assets. Examples of liquid assets include, but are not limited to checking, saving, & money market accounts, COs, and bonds.
20) Non-liquid assets as defined by requirements according to Mississippi Department of Health and Human Services’ Medicaid MA-2230 Financial Resources definition for countable real property will be considered in assessing financial assistance eligibility. A patient's equity in real property, when compared to the tax value, will be considered a non-liquid asset. The patient's primary residence will be excluded. Patients will be made aware of this provision at time of application for financial assistance.
The following will not be considered income:
1) Food or rent received in lieu of wages
2) Non-cash benefits
3) Payments from student loans and grants
4) Child Support payments

The following may be used to prove income:
1) Federal and state income tax returns for the prior calendar year.
   Self-employed patients are to provide Schedule C of their federal income tax return (Schedule C). The following deductions will not be allowed in determining income:
   a. Depreciation
   b. Travel, Meals, & Entertainment
   c. Expenses listed as "Other" on Schedule C will be evaluated on an individual basis
2) W-2 Form(s), or other IRS income forms, included with the prior calendar year tax return filing.
3) Payroll check stubs covering the last six weeks are required. When check stubs are unavailable, telephone verification from employer verifying employment and income is acceptable. Telephone verification may only be performed by an authorized Rush Health Systems, RMG, and MFI employee to the applicant's Human Resource Representative, not vice-versa. The Rush Health Systems, RMG, and MFI employee must document in the system and/or record the following:
   a. Company name
   b. Date, time of phone call
   c. Phone number called
   d. Person at applicant's place of employment verifying income
4) Other current income from any source not directly related to employment, such as retirement or disability benefits, Social Security, or Veteran's Benefits must be verified with check stubs or other documentation.
5) The most recent checking & savings account statements.
6) Patients who are employed, but due to a temporary medical condition rendering them unable to work are not drawing an income, will have their annual income reduced by the period of inability to work. This pro-rated income will be used in determining the patient's eligibility for financial assistance.
   Example: The income of a patient with an annual income of $40,000 who is unable to work for 12 weeks will have a pro-rated annual income of $30,000 for the purposes of determining eligibility for financial assistance.
7) In instances when the patient states that the above supporting documentation does not exist, the patient will be required to provide a statement attesting to their income.

Unemployment may be documented by presentation of:
1) Mississippi or Alabama Employment Security Commission documents
2) Letters from state and local agencies on their letterhead
3) In the absence of any of the above, patients who are unemployed are required to document how their expenses are being paid. These requirements will be waived for patients of retirement age as published by Social Security.
The following calculations will be used to determine income:

1) Checking and Savings Accounts - Excluding deposits of income already calculated or excluded due to policy (child support, student loans or grants), take ending balance from each statement and add all other deposits. Add the three monthly subtotals and divide the amount by three to obtain a monthly average. The average amount is then added as a one-time amount to annual income.

2) Money Markets, Stocks, Bonds, and Certificates of Deposit - Add 100% of value toward annual income.

3) Individual Retirement Accounts - Do not count when funds not being drawn. When funds being drawn, take amount received per month and multiply by number of months received in a year. Add to annual income.

4) Pay Stubs, Retirement Accounts, Social Security Disability (SSD), and Supplement Security Income (SSI)- Take amount received per month and multiply by number of months received in a year. If paystubs are hourly, take hourly amount and multiply by number of hours worked per week. Use table below to calculate monthly amount. Multiply monthly amount times the number of months worked per year. If salaried, use table below to calculate monthly amount, as needed. Multiply monthly amount times the number of months worked per year.

5) Real Estate Owned (other than primary residence)- Take the tax value minus the remaining mortgage amount due to calculate the equity. Equity is then added to total annual income.

6) Self-Employment - Includes depreciation, meals and travel, gifts, and entertainment obtained from Schedule C.

### Converting income to a gross monthly paid weekly Multiply by 4.3
paid biweekly Multiply by 2.15
paid semimonthly Multiply by 2
paid monthly Use the gross month

5) Real Estate Owned (other than primary residence)- Take the tax value minus the remaining mortgage amount due to calculate the equity. Equity is then added to total annual income.

6) Self-Employment- Includes depreciation, meals and travel, gifts, and entertainment obtained from Schedule C.

**Family Size-** A family is a group of two or more persons related by birth, marriage, or adoption that live together. All such related persons are considered as members of one family. Family members are defined as follows:

1) The patient and, if married, his/her spouse
2) Any natural, or adopted minor child of the patient, or spouse who has not been emancipated by a court and who is not, or has never been, married.
3) Any minor for whom the patient or patient's spouse has been given the legal responsibility by a court
4) Any person designated as "dependent" on the patient's latest tax return
5) Any student over 18 years old who is dependent on the patient's family income for over 50 percent support
6) Any other person dependent on the patient's family income or over 50 percent support
7) Any other person dependent on the patient's family income or over 50 percent support

Dependency is determined by one of the following documents that contain the patient's or patient's spouse's name:

1) Current tax return
2) Court-ordered guardian/conservatorship
3) Birth certificate
4) Baptismal record
5) Social Security award letter
6) U.S. Immigration documentation
7) In the absence of any of the above, a signed affidavit from the patient witnessed by a Rush Health Systems, RMG, and MFI representative attesting to the dependency of minor child or other family member
8) A minor is one who has not reached his/her eighteenth (18th) birthday and who is not and has never been married. When the marital status of the minor cannot be determined, or when there is no documentation indicating the patient is an emancipated minor, the parents or legal guardian should be designated as the responsible party. The parents or guardian's income and residence should be used to determine eligibility for financial assistance. Legal guardianship must be supported by fully executed and valid legal documents.

9) Unmarried college students or individuals 26 or under, must submit parent income and reason for lack of coverage under parent insurance policies.

Proof of family size will be based on the most current filed Federal Tax form in accordance with the IRS tax laws. A birth certificate(s) must be presented to validate an increase in the family unit above the total claimed on the most recent tax return. If no tax return is provided, the family size will be calculated as one.
Appendix G

Form of Application for Rush Health Systems, Financial Assistance Program

Date
Name
Address
MRN

This form will be used by the hospital to determine if you qualify for a discount according to Rush Health Systems’, Financial Assistance guidelines.
In addition to completing the attached Financial Assistance Application, the following information is needed for eligibility. Listed below is the documentation necessary to support the need for financial assistance. If you are legally married and your spouse is a part of your household please provide their tax information and proof of income.

Tax Information
- Required: Tax return OR IRS non-filing letter

Did you file a tax return in (enter prior year)?
IF YES, then please send the following

☐ Federal Tax Return - most recent year end
  (If you own your own business, include a profit or loss and the depreciation and amortization forms; include worksheets for any expenses listed as other on your profit or loss statement)

IF NO, then please send the following

☐ IRS Letter - notice of non-filing taxes
  (Call the IRS at 1-800-829-1040 to obtain legal filing letter)

Proof of Income Required: all of the items listed below that apply
☐ W-2 or 1099 - same year as the tax return
☐ Current Income - 6 weeks current check stubs.
☐ Social Security - official government letter or bank statements showing direct deposits
☐ Unemployment Benefits - approved letter or pending letter
☐ No Income - Please provide a letter showing how you are paying your expenses.

Personal Verification Required:
☐ Picture I.D. - Must have a Mississippi or Alabama Drivers License or I.D. Card
☐ If you do not have a Mississippi or Alabama Drivers License, please provide proof of residency - Lease Agreement, Permanent Residency Card, Checking Account Statement, Utility Bill, etc.

Other Information
☐ Medicaid or Medicare denial letter - if applicable
☐ Divorce Decree - if divorce date is after date of tax return
☐ Notarized Marital Separation Letter - if separation date is after date of tax return

Submission of Information
You have 30 days to submit this information. If the information is not submitted in full within 30 days from
the date of this letter, the application will be denied for noncompliance. Submit information either by mail or deliver in person. Mailing and delivery address are listed below:

**Your deadline date is:**

**Mail**

Applications can be mailed to:

Rush Health Systems,

**Attention:** Financial Assistance Program

1121 18\textsuperscript{th} Ave

Meridian, MS 39301

**Applications may be brought in person to the Hospital**

Applications may be brought in person to Customer Services located in the Rush Business Services Building.

Located at 1121 18\textsuperscript{th} Avenue, Meridian, MS 39301

**Notification of Determination**

You will receive written notification of your eligibility for our Financial Assistance program within 30 working days of Rush Health Systems, receiving your completed application and documentation. If you have any questions concerning this application, please call the Customer Services Department at 601-703-9393.

Rush Health Systems, reserve the right to deny or withdraw any financial assistance application and to pursue legal action should any part of this application prove to be intentionally falsified.
### Applicant Information

Applicants Name: ____________________________ Applicant’s Social Security#: __________________

Applicants Date of Birth: ________________ Applicant’s Age: ________________ Applicant’s Sex: __________

Marital Status: __ Single __ Married __ Separated (Date __) __ Divorced __ Date __) __ Widowed

Home Address: ____________________________ Apt or Lot # __________

City: ____________________________ County: ____________ State: ______ Zip: ____________

Mailing address (if different from Home address):

City: ____________________________ County: ____________ State: ______ Zip: ____________

Home Phone or Cell # ______ (____) ______ Work Phone # ______ (____) ______

May we contact you at work? __ Yes __ No

Message # if no phone ______ ______ Whose# is this? ______ ______

### HOUSEHOLD MEMBERS (List all persons living in the household and relationship to the applicant.)

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Social Security Number*</th>
<th>How is this person related to you?</th>
<th>Date of Birth (MM/DD/YYYY) (for all applying, attach proof of birth)**</th>
<th>Sex (M/F)</th>
<th>Race***</th>
<th>US Citizen? (Indicate all that apply)</th>
<th>Pregnant? (For all applying)</th>
</tr>
</thead>
<tbody>
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NOTE: Legal parents & spouses living in the home must be listed, even if not applying.
List all earnings from employment and self-employment that you, your spouse and children in your household receive. You must provide proof of your household's most recent income. Your Financial Counselor will explain to you what is acceptable verification for your family. Only the income of legal parent(s) living in the home is used to determine children's eligibility.

<table>
<thead>
<tr>
<th>Name of Person Working</th>
<th>Gross Amount Paid (include tips, recurring overtime)</th>
<th>Name of Employer, Address &amp; Phone Number</th>
<th>How often paid?</th>
<th>Employment Start Date?</th>
<th>Is Insurance Available?*</th>
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List all unearned income received by you, your spouse and children in your household. Examples include Social Security benefits, SSI, TANF, Veteran's benefits, unemployment benefits, worker's compensation, alimony, cash contributions, interest, royalties, dividends, rental income and educational income.

<table>
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<tr>
<th>Name of Person Receiving Payments</th>
<th>Type of Payment</th>
<th>Gross Amount of Payment</th>
<th>How Often Received</th>
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If you are eligible for certain benefits, such as unemployment compensation, you must apply if you want to be eligible.

Does any person you are applying for already have health insurance coverage, including Medicaid, Alacaid, or CHIP? **Yes** No

Has any person listed on the application had health insurance coverage, including Medicaid, Alacaid, or CHIP, that ended within the last 6 months?
The Financial Assistance Program covers charges medically necessary to hospital and physician services.

All services provided by Rush Health Systems are not covered under the Financial Assistance Program (If you have questions, please 601-703-9393).

Elective or experimental procedures may not be covered.

Compliance with all Medicaid, Alacaid, or other private agency funding sources, is required. Failure to cooperate and complete required application processes for Medicaid, or other private agency funding sources, may result in a denial of Rush Health Systems’ Financial Assistance and the patient will be responsible for all charges.

You have 30 days to submit the completed application and support information. If the information is not submitted in full within 30 days from the date of this letter, the application will be denied for noncompliance.

If additional information is requested once application is received, you will have an additional 15 days to submit information. If the information is not submitted in full within this timeframe, the application will be denied for noncompliance.

You will receive written notification of your eligibility for our Financial Assistance Program within 15 days of Rush Health Systems receiving your completed application and documentation.

SIGNATURE

I authorize any person, employer, financial institution or credit reporting agency with records regarding any of the requested information on the application to release this information to Rush Health Systems. I understand that, should this request for financial assistance be denied for any reason, I will be fully responsible for financial obligations arising from hospital and physician services. I hereby certify that I have read and understand the above statements. The information contained in this application is true, correct, and complete. I also understand that Rush Health Systems may take legal action against me if any information provided on the application has been knowingly falsified.

__________________________________________ Date

Signature of applicant or guarantor (required)

*** Please note that all information contained in this application is deemed confidential and will only be used to assist with being compliant to state and federal laws.
Appendix H

Form of Attestation Regarding Unchanged Financial Documentation

I, ____________________________, did apply to _____________________ for Financial Assistance and was approved for Financial Assistance on ________________________.

I am now requesting Financial Assistance from the _____________________ Financial Assistance Program for a different episode of care.

I hereby declare that the date of this application is within twelve months following the date (indicated above) on which my Financial Assistance application was approved.

I hereby declare that I am an Alabama/Mississippi resident.

I hereby declare that the information contained in the Financial Assistance application indicated above remains true and accurate in all respects as of today’s date, including all information about my income amounts and sources.

I understand that a false or misleading declaration by me may result in my receiving financial assistance adjustments and benefits for which I would not otherwise have qualified. I understand that making false or misleading statements in connection with my application may subject me to civil and criminal penalties as well as result in a denial of my application.

__________________________________________
Signature

__________________________________________
Date

__________________________________________
Address

__________________________________________

__________________________________________

Telephone No ____________________________