INFIRMARY HEALTH
More devoted to Your life.

Financial Assistance Policy – Plain Language Summary

The Infirmary Health (IH) Financial Assistance Policy/Program (FAP) exists to provide eligible patients, partially or fully-discounted emergent or medically-necessary hospital care. Patient seeking Financial Assistance must apply for the program, which is summarized herein.

Eligible Services – Emergent and/or medically necessary healthcare services provided and billed by hospitals affiliated with IH: Mobile Infirmary Medical Center, Thomas Hospital, North Baldwin Infirmary, Infirmary West, and Infirmary LTAC Hospital. The FAP only applies to services billed by such Hospitals. Other services which are separately billed by other providers, such as physicians or laboratories, are not eligible under the FAP.

Eligible Patients – Patients receiving eligible services, who submit a complete Financial Assistance Application (including related documentation/information), and who are determined eligible for Financial Assistance by the IH Financial Assistance Committee.

How to Apply – Financial Assistance Applications may be obtained/completed/submitted as follows:

- Obtain an application at each hospital's main Registration desk or Emergency Room desk.
- Request an application be mailed to you, by calling IH Patient Business Services Dept. at 251-435-3541.
- Download an application from the IH website: https://www.infirmaryhealth.org/financial-assistance.
- Mail completed applications (with all documentation/information specified in the application instructions) to: IH Patient Business Services Dept., Mobile Infirmary Medical Center, P.O. Box 2144, Mobile, Alabama 36652.

Determination of Financial Assistance Eligibility – Generally, Eligible Patients are eligible for Financial Assistance, using a sliding scale, when their Family Income is at or below 350% of the Federal Government's Federal Poverty Guidelines (FPG) (https://aspe.hhs.gov/poverty-guidelines); Eligibility for Financial Assistance, means that Eligible Persons will have their care covered fully or partially, and they will not be billed more than "Amounts Generally Billed" (AGB) to insured persons (AGB, as defined by IRS Section 501 (r)). Financial Assistance levels, based solely on Family income and FPG, are:

Family income at 0 to 200% of FPG	⇨	Full Financial Assistance $0 is billable to Patient
Family income at 201 to 350% of FPG	⇨	Partial Financial Assistance; AGB is max billable to Patient

Note: Other criteria beyond FPG are also considered (i.e., availability of cash or other assets that may be converted to cash, and excess monthly net income relative to monthly household expenditures), which may result in exceptions to the preceding. If no Family Income is reported, information will be required as to how daily needs are met. The IH Financial Assistance Committee reviews submitted applications which are complete and determines Financial Assistance Eligibility in accordance with the IH Financial Assistance Policy. Incomplete applications are not considered, but applicants are notified and given an opportunity to furnish the missing documentation/information.

For help, or questions, please call: IH Patient Business Services Dept. at 251-435-3541, Monday - Friday 8 a.m. to 4:30 p.m.

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Financial Assistance Application - Instructions

Thank you for contacting Infirmary Health regarding your hospital account(s). You may complete a Financial Assistance Application Form to apply for Financial Assistance with your hospital patient account(s) at the following entities:

Mobile Infirmary Medical Center
Infirmary Long Term Acute Care (LTAC) Hospital
North Baldwin Infirmary
Thomas Hospital

We are happy to review your hospital patient account(s) for financial assistance, but respectfully request that you submit the applicable documentation below. We encourage you to submit complete and accurate documentation so that we may appropriately consider your request for Financial Assistance.

____ **Latest/Current Federal and State income tax return.** If you did not file income tax returns, please call the Internal Revenue Service for a verification letter reflecting no federal income tax return was filed. This letter may be obtained by calling 1-800-829-1040 or 1-800-829-0922.

____ **Latest/Current Banking/Investment statements.** Provide the last 2 monthly statements for all active accounts: checking, savings, and investment accounts.

____ **Documents supporting income:** Provide 2 most recent paystubs, and/or documentation of child support, alimony, and government benefits.

____ **Completed and signed Financial Assistance Application Form.**

Our mailing address is: Infirmary Health, Attn: Patient Business Services Dept., P.O. Box 2144, Mobile, Alabama 36652. We ask you to please mail the requested information as soon as possible so our consideration may be as timely and current as possible. After the information has been received, it will be presented to our Financial Assistance Committee for review. You will be notified of the outcome of your application in writing. If you have any questions, please contact our Patient Business Services Department at (251) 435-3541.

Sincerely,

Financial Assistance Coordinator
Infirmary Health

INFIRMARY HEALTH

P.O. Box 2144, Mobile, AL 36652 • 251-435-3541

FINANCIAL ASSISTANCE APPLICATION FORM

Please list the account number and facility name for each account for which Financial Assistance is requested.

Account Number	Facility Name	Account Number	Facility Name
Account Number	Facility Name	Account Number	Facility Name
Account Number	Facility Name	Account Number	Facility Name

Patient/Guarantor: _____ Social Security #: _____

Address: _____ Telephone #: _____

_____ Date of Birth: _____

Spouse Name: _____ Social Security #: _____

Address: _____ Telephone #: _____

_____ Date of Birth: _____

Name and ages of persons living in household:

Name	Age	Relationship	Do you claim this person for tax purposes?

Income:

Patient/Guarantor Employer: _____

Employer's Address: _____ Telephone #: _____

_____ Job Title: _____

Gross Income: $_____ Hr./Wk./Mo. Net Income: $ _____ Hr./Wk./Mo.

Income:

Spouse's Employer: _____

Employer's Address: _____ Telephone #: _____

_____ Job Title: _____

Gross Income: $_____ Hr./Wk./Mo. Net Income: $ _____ Hr./Wk./Mo.

Rev. 2019Oct01

Other Income (including second job, government benefits, child support, etc.)

Source:_____ Gross: $ _____ Net: $ _____ Hr./Wk./Mo.

Source:_____ Gross: $ _____ Net: $ _____ Hr./Wk./Mo.

Source:_____ Gross: $ _____ Net: $ _____ Hr./Wk./Mo.

Financial:

Checking Account: Name of Bank:_____ Balance $_____

Savings Account: Name of Bank:_____ Balance $_____

Investment Account: Name of Bank/Company:_____ Balance $_____

Other Accounts: Name of Bank/Company:_____ Balance $_____

Expenses:	MonthlyPayment	Owed To	Balance
Mortgage/Rent	$		$
Auto Loan	$		$
Auto Loan	$		$
Furniture/Appliances	$		$
Credit Card	$		$
Credit Card	$		$
Gas (for home)	$		$
Water	$		$
Power	$		$
Telephone	$		$
Cell Phone	$		$
Cable	$		$
Gas (auto)/bus fare	$		$
Child Care	$		$
Insurance	$		$
Insurance	$		$
Groceries	$		$
Prescriptions	$		$
Doctor/Clinic	$		$
Doctor/Clinic	$		$
	$		$
	$		$

Property:

House Location:_____ Purchase Date:_____ Present Value $_____

Land Location: _____ Purchase Date:_____ Present Value $_____

Automobile: Year:_____ Make/Model:_____ Current Value $_____

Automobile: Year:_____ Make/Model:_____ Current Value $_____

Automobile: Year:_____ Make/Model:_____ Current Value $_____

Please explain your current situation and your need for Financial Assistance: (If additional space is needed, please continue on separate page.)

_____

_____

_____

_____

_____

_____

_____

Statement of Truth

The information in this application for financial assistance, concerning my financial situation, is both complete and correct to the best of my knowledge. I understand that information given within this document is for the purpose of determining eligibility for financial assistance and that false or incomplete information will result in my disqualification for financial assistance. I agree to grant the hospital access to any records necessary to verify the information given in this application. I understand that eligibility for financial assistance will not be approved until verification of my financial situation, and that any changes or corrections found will be applied to the application before determination of eligibility is made. I also understand that if my request for financial assistance is not approved based on the criteria given within this form that I may ask for special approval from the hospital and the Board of Directors and also through the President. I understand that their decision will be made only on the basis of extraordinary circumstances applying to my case, and that their decision will be final. I also verify that all other sources of funds which may be available to me for payment of this medical expense have been exhausted, including all State or Federal medical funds. However, should funds be available from any public or private source to cover any medical expense which might be associated with the care which is the basis of this application, I agree to apply for such funds. I also hereby authorize Infirmary Health to pursue such funds, and/or make application on my behalf, by sharing any information I may have submitted herein. I hereby authorize Infirmary Health, which includes, Mobile Infirmary Medical Center, Thomas Hospital, North Baldwin Infirmary, and Infirmary LTAC Hospital to make/share whatever credit inquiries/information they deem necessary in connection with this application or in the course of review or collection of any credit extended in reliance on this application. I authorize and instruct any person or consumer reporting agency to compile and furnish the hospital(s) any information it may have or obtain in response to such credit inquiries and agree that same shall remain your property whether or not credit is extended. I acknowledge receipt of the notice printed below provided by the hospital(s) to me at the time this application is made. Further, I hereby affirm that all statements made in this application are true and are given for the purpose of obtaining financial assistance.

_____ _____

Patient/Guarantor Signature Date

_____ _____

Signature of Spouse (if married) Date

Notice: The Federal Equal Credit Opportunity Act prohibits creditors from discriminating against credit applicants on the basis of sex or marital status. The Federal agency which administers compliance with this law concerning the Infirmary Health is the Federal Trade Commission, Washington, D.C. 20580.