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VALLEY HEALTH OFFERS DIFFERENT OPTIONS TO SETTLE ACCOUNTS:

1. Payment in full upon receipt of first statement or letter, or, Payment plans to pay in full
2. Assistance with enrolling in Medicaid.
3. Full or Partial Financial Assistance is available for patients who do not qualify for Medicaid.
4. This Financial Assistance application **does not apply** to Urgent Care accounts, Valley Home Care accounts, Valley Gateway Home care accounts, Valley Medical Transport accounts, or Occupational Health accounts. A separate application must be obtained for these services by calling Valley Regional Enterprises (VRE) at 1-866-887-9008.

Valley Health Financial Counselors are available to answer any questions and help you determine the most appropriate option for your particular needs and can be reached by calling **1-866-414-4576**. It is recommended that you review the full Financial Assistance Policy before applying.

1. COMPLETE ALL PAGES OF THE FINANCIAL ASSISTANCE APPLICATION. As Patient and/or Guarantor/Spouse, you and your spouse must sign and date this application. List any payments that are past due. If the information requested does not apply, answer **"N/A"**.

2. SUPPORTING DOCUMENTATION: THE FOLLOWING DOCUMENTATION IS NECESSARY TO REVIEW YOUR FINANCIAL ASSISTANCE APPLICATION AND THE APPLICATION WILL BE DENIED IF ALL NECESSARY DOCUMENTATION IS NOT SUPPLIED. SEE THE FINANCIAL ASSISTANCE POLICY (FAP) "INCOME DOCUMENTATION" SECTION" FOR ADDITIONAL INFORMATION:

- ☐ CURRENT PROOF OF ALL INCOME IN YOUR HOUSEHOLD
- ☐ A copy of the most recent tax return(s) for all legally responsible family members age 18 or older. If spouses file separately, you must send both returns. If you do not have a copy of your return, you can obtain a transcript from the IRS at 1-800-829-1040.
- ☐ Copies of one month's pay stubs for the most recent month available for all responsible family members.
- ☐ Written income verification from an employer if paid in cash.
- ☐ Copies of bank statements of all checking, savings, and investment accounts for the two prior months.
- ☐ Copies of stubs/statements/or checks of Social Security, pension, disability, workers compensation, unemployment, and/or documentation of other sources of income.
- ☐ Verification of alimony and/or child support.
- ☐ If you have no income or another person is paying your living expenses, you must explain this in the application question: "**If no income is listed**".
- ☐ Copies of all outstanding VHS medical bills so that the VHS Financial Counselors can include all outstanding VHS medical debt.
- ☐ If applying for Catastrophic Financial Assistance: Proof of residency within the VHS primary or secondary service areas and all outstanding medical bills from Valley Health and non-Valley Health healthcare providers incurred since the onset of the injury or illness.
- ☐ **If Asset varication is required (see ASSETS section of the application), include the most recent statement(s) or other documentation:** Savings, Checking, IRA's, or other retirement accounts. Value of stocks, bonds, money markets, etc. It is recommended that you redact any account numbers referenced on such documentation.

ADDITIONAL INFORMATION MAY BE REQUESTED IN ORDER TO COMPLETE THE PROCESSING OF YOUR APPLICATION AND ALL INFORMATION PROVIDED IS SUBJECT TO VERIFCATION.

"This is an attempt to collect a debt and any information obtained will be used for that purpose"

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PLAIN LANGUAGE SUMMARY (PLS)

This Plain Language Summary, including the following "**HOW TO APPLY**" section, provides a brief overview of the Valley Health System (VHS) Financial Assistance Policy (FAP) and availability of VHS Financial Assistance, formerly called "Charity Care", and Financial Counseling services. The complete FAP provides a more in depth description of the availability, providers and locations to which this policy applies, and rules governing Financial Assistance availability and Financial Counseling services. The complete FAP is available online free of charge at **http://www.valleyhealthlink.com/FinancialAssistance** Paper copies of the FAP may be obtained free of charge by contacting the Financial Counseling Department or in person as specified below under "**HOW TO APPLY**". Translations are available in languages that are prevalent in the communities served by VHS.

Valley Health offers Financial Counseling services, including Certified Application Counselors (CACs), to help VHS patients and the family members financially responsible for the bills of Valley Health patients who are concerned about their ability to pay for medical services provided by VHS to identify means to cover the cost of medically necessary care. VHS offers a Financial Assistance Program to assist those who are truly unable to pay for emergency or medically necessary care. The purpose of VHS Financial Counselors is to serve as guides to patients and guarantors in need of assistance. Financial Counselors are available to answer questions, work with patients and caregivers to identify the programs that are most appropriate for each patient's particular needs and ability to pay, to assist in the Financial Assistance Application process, to assist with the application, enrollment, or referral to the various government assistance or insurance programs that may be appropriate to the patient's needs, as well as to establish payment plans for those who do not qualify for Financial Assistance or any other program. Further, as part of the Financial Counseling services available to VHS patients and guarantors, VHS maintains Certified Application Counselors (CAC's) to assist patients/guarantors in applying for Health Exchange plans during Open Enrollment and Special Enrollment Periods (SEP) as allowed by the Affordable Care Act (ACA). These CAC's are also available throughout the year to assist in explaining the Health Exchange and how it works. It is strongly recommended that patients and caregivers concerned about their ability to pay for medically necessary services contact the VHS Financial Counselors at the earliest opportunity, including prior to future, expected medically necessary services, in order that the Financial Assistance or other assistance programs can be in place to cover the greatest amount of care possible and to avoid unnecessary self-pay billing and collection activity.

Types of Financial Assistance Available: For patients and guarantors that are not eligible for Medical Assistance or other assistance programs, Financial Assistance is available and generally based on family income. A 100% Financial Assistance discount is available for patients/guarantors with a combined family income of less than 200% of the Federal Poverty Level (FPL). For families with incomes between 200% and 300% of FPL, partial Financial Assistance is available on a sliding-scale. For families with incomes between 300% and 500% of FPL, Catastrophic Financial Assistance discounts are available if medical bills exceed 30% of family income. Patients/Guarantors that are eligible for partial Financial Assistance and Catastrophic Financial Assistance will be billed no more than the Amounts Generally Billed (AGB) billed to insured individual. Please see the full FAP and explanation of how AGB and partial discounts are calculated. Financial Assistance awards may be reduced if significant assets, as described in the full FAP, are available to help cover the cost of medical care.

All United States citizens and, permanent residents of the United States, and individuals who intend to stay in the United States as permanent residents are eligible for Financial Assistance. Patients/Guarantors who are not permanent residents of the United States, do not intend to remain permanently in the United States, or are in the United States on a student visa or tourist visa are not eligible for VHS Financial Assistance. Financial Counseling services are available to all patients/guarantors of VHS.

HOW TO APPLY: Patients and caregivers are encouraged to contact:

- VHS Financial Counselors at **866-414-4576** at the earliest possible opportunity.
- The VHS Financial Assistance Application can be found online at **http://www.valleyhealthlink.com/FinancialAssistance**. Paper copies of the Financial Assistance Application may also be obtained without charge at VHS registration desks at each VHS hospital and Emergency Department, in writing to the address below, or by calling the VHS Financial Counselors at the number above. Correspondence, including requests for Financial Counseling assistance, Financial Assistance, completed Financial Assistance Applications, and supporting documentation may be submitted in writing to:

Financial Counseling Dept. Valley Health System
P.O. Box 3340
Winchester, VA 22604

- In person assistance is also available from 9:00 am to 4:00 pm, Monday through Friday, excluding holidays, at the following locations below. Although appointments are recommended and can be made by calling the VHS Financial Counseling phone number above, walk-ins are accepted within the specified hours and based upon availability of the individual Financial Counselors.
  - Hampshire Memorial Hospital: Main hospital lobby, MedAssist office.
  - Page Memorial Hospital: Main hospital lobby at the walk-up window.
  - Shenandoah Memorial Hospital: Main hospital lobby, Financial Counselors office (near Cashier's window)
  - War Memorial Hospital: Main hospital lobby, MedAssist office.
  - Warren Memorial Hospital: Business Office at Warren Memorial.
  - Winchester Medical Center Campus:
    System Support Building (SSB), 220 Campus Blvd, Suite 210 Winchester, Virginia

RETURN APPLICATION TO :

P.O. Box 3340, Winchester, Virginia 22604-2540 OR Fax to: 540-536-3288, OR e-mail to financial.counselor@valleyhealthlink.com

2-21-17

ValleyHealth
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Phone # 866 – 414 - 4576

Fax #: 540 – 536 – 3288

FINANCIAL ASSISTANCE APPLICATION

Account or Guarantor Number from your Valley Health Bill: _____

Guarantor	**Co-Guarantor/Spouse**
If applying for Financial Assistance for a dependent child under age 21, information is required from both parents.	
First Name Middle Initial Last Name	First Name Middle Initial Last Name
Soc. Sec # / Date of Birth / # of Dependent Children (Living in home) & Ages	Soc. Sec # / Date of Birth / # of Dependent Children (Living in home) & Ages
O Married (legally) O Separated – how long? _____ O Unmarried (include single, divorced, widowed)	O Married (legally) O Separated – how long? _____ O Unmarried (include single, divorced, widowed)

List all Patients, including the Guarantor, Co-Guarantor, minor children, and other legal dependents. Attach a separate sheet if necessary.

Name	**Date of Birth**	**SSN**	**Employed?**	**Relationship to Guarantor**
_____	___/___/_____	___-___-_____	Y / N	_____
_____	___/___/_____	___-___-_____	Y / N	_____
_____	___/___/_____	___-___-_____	Y / N	_____
_____	___/___/_____	___-___-_____	Y / N	_____
_____	___/___/_____	___-___-_____	Y / N	_____

Present Address _____ _____ Phone ( ) _____ How Long: _____ years ____ months	Present Address _____ _____ Phone ( ) _____ How Long: _____ years ____ months
O Buying O Own O Renting O Live with parents / family / friend	O Buying O Own O Renting O Live with parents / family / friend
Employer Name & Address _____ _____ Phone: Hire Date:	Employer Name & Address _____ _____ Phone: Hire Date:
How Long ___yrs____mos / Position / Gross Mo. Income	How Long ___yrs____Mos. / Position / Gross Mo. Income
Other Income $ / Source	Other Income $ / Source
Nearest relative not living with you: Relationship: _____ Name _____ Address _____ Phone: ( ) _____	Nearest relative not living with you: Relationship: _____ Name _____ Address _____ Phone: ( ) _____

The undersigned certify that all statements made herein are true and complete and to be relied upon by Valley Health (VH) and/or its assignees and are made to induce VH and/or its assignee to extend credit or financial assistance. The undersigned authorizes VH and/or its assignee to investigate their credit, verify employment history, and release information about VH and/or assignees credit experience with them. All information provided on this application is subject to verification at the discretion of VHS.

Guarantor _____ Date _____ Co-Guarantor _____ Date _____

If no employment/income, what was your last day of employment (self)_____(spouse) _____

Are you or your spouse receiving unemployment benefits? Yes_____/ No_____
If yes, how much per month? $_____ (enclose copy of Benefit Payment History from Employment Commission)

Did your household receive any money from any place else? Yes_____/ No_____

If yes, from where_____how much per month $_____

If no income listed, EXPLAIN how are you paying your expenses?_____

_____

If someone else is paying your expenses, state who and your relation:_____

Are you claimed on someone else's Taxes: Yes_____/ No_____. If Yes, who (name and relationship):_____
Did YOU file Income Taxes in the most recent year? Yes_____/ No_____.

IF YOU FILED INCOME TAXES: How many dependents/exemptions did you claim on last year's Tax Return? (include self, spouse, children) _____

Will there be a change in number of dependents/exemptions claimed on this year's tax return, if so explain changes_____

_____

MONTHLY HOUSEHOLD EXPENSES

I. List all loans, credit cards, etc.

To Whom Indebted	Monthly Payment	Present Balance	Current: Y/N?
1. Rent / Mortgage:			
2. Vehicle Loan:			
3			
4.			
5.			
6.			
7.			
8.			

II. Monthly Household Expenses

Food: _____

Car Expense:_____(Gas/Repairs)

Electricity: _____

Water: _____

Phone: _____

Gas: _____(Heat/Propane)

Other: _____

Medicine: _____

Life Insurance: _____

Auto Insurance: _____

Homeowners Ins. _____

Health Insurance: _____

Cable: _____

ALL SUBMITTED INFORMATION IS CONFIDENTIAL

OTHER INCOME

III. List all sources of income for the Guarantor and Co-Guarantor/Spouse and other family members. Pay stubs, statements, or other supporting documentation is required for each source of income

Source/Description	Avg. Monthly Income	Paid by	Paid to
1. Guarantor Primary Income (employee wages or self-employment income)			
2. Guarantor Secondary Income(employee wages or self-employment income)			
3 Co-Guarantor Primary Income(employee wages or self-employment income)			
4. Co-Guarantor Secondary Income(employee wages or self-employment income)			
5. Other responsible family member income(employee wages or self-employment			
6. Social Security benefits			
7. Railroad and/or Veterans Benefits			
8. Dividend or Interest Income greater than $10/month			
9. Alimony and child support			
10 Unemployment and Workers Comp benefits			
11. Other Income (Describe)			
12. Other Income (Describe)			

ASSETS

If you owe or expect to owe Valley Health $500 or more in medical expenses, please review the Valley Health Financial Assistance Policy for an explanation as to which and at what level assets may be considered as recoverable as part of the VH Financial Assistance Calculation. A copy of the most recent account statement will be required for each account listed.

IV. If you owe or expect to owe Valley Health $500 or more in medical expenses, list all cash on hand, and the value of any personal checking and savings accounts owned or co-owned by the guarantor or the co-guarantor and available for the personal use and benefit of the guarantor and/or co-guarantor. Do not include college savings plans or college savings trust funds. Do not list account numbers and please redact account numbers from any statements you submit with this applicate.

Account Type/Institution	Do You Have:	Owner (Guar/Co-Guar)	Jointly owned?
1. Cash on hand	$_____.____		
2. Checking Accounts	YES or NO If YES, provide statements		
3. Savings Accounts	YES or NO If YES, provide statements		
4. Other available accounts	YES or NO If YES, provide statements		

V. For applicants with a combined outstanding medical debt from Valley Health exceeding:

- $10,000.00 but less than $25,000.00, list the present value of any stocks, bonds, or other investment instruments that are under the control of and available for the personal use and benefit of the guarantor, excluding any accounts designated as retirement accounts under IRS rules.
- $25,000.00, list the present value of all 401K, 403B, IRA, Roth IRA, or other IRS-designated retirement savings plans. Do not list account numbers. DO NOT INCLUDE College Savings accounts. If more space is required, attach a separate sheet of paper with your name and Valley Health Account numbers.
- Do not list account numbers and please redact account numbers from any statements you submit with this application.

Description, Type of Retirement Account, and owner	Current Market Value (Last statement value is sufficient)

VI. For applicants with a combined outstanding medical debt from Valley Health exceeding $25,000.00, list all real estate, including your primary residence, second home, other homes, rental, investment and other real property owned by the guarantor or co-guarantor.

Address	**House, Business, raw land, or other (describe)**	**Purchase Price**	**Purchase Date**	**Outstanding Mortgages, Lines of Credits, Liens**	**Last Appraised Value**	**Last Appraisal Date**	**Estimated Current Equity**
Primary Residence							

Please include a separate sheet to include any additional information you believe may be pertinent to the application review.

CASE NAME _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the following information to be released to Cathy Alger, Pam Griffith, Cindy Lauritzen, Shannon Nuckles, Pam Turner, and employees of Valley Health:

Verification that a Medicaid application has been filed
Copy of Needs list
Notice of Action.

I _____, am signing this form

FULL PRINTED NAME OF CONSENTING PERSON OR PERSONS authorizing the release of this information.

The agency will not give information about you in its records without your authorization. By signing below you give your authorization.

Signed: _____ Date: _____
Client

CASO _____

AUTORIZACIÓN PARA DAR INFORMACIÓN

Cathy Alger, Pam Griffith, Cindy Lauritzen, Shannon Nuckles and Pam Turner, y empleados de Valley Health, están autorizadas para recibir información acerca de:

Verificación de haber llenado una solicitud para Medicaid
Copia de la Lista de Necesidades para Medicaid
Notificación de la decisión tomada con respecto a mi solicitud para Medicaid o para SLH

YO _____, firmo este

NOMBRE COMPLETO EN LETRA DE IMPRENTA DE LA PERSONA O PERSONAS

documento para autorizar se haga entrega de esta información.

La agencia no dará información de su caso sin esta autorización. Al firmar este documento, usted da consentimiento para que la información sea divulgada.

Firma: _____ Fecha: _____
Cliente