ValleyHealth

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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**, or **e-mail To: PBDValleyHealth@ensemblehp.com.** Please 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 Verification 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"

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 notice of availability of VHS Financial Assistance, formerly called "Charity Care", and VHS Financial Counseling services. The complete FAP provides a detailed description of the availability, providers, and locations to which this policy applies, and the rules governing FAP availability and Financial Counseling services. The complete FAP is available online free of charge at http://www.valleyhealthlink.com/charitycare. Paper copies of the FAP may be obtained free of charge by contacting the Financial Counseling Department by phone, e-mail, 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 to help VHS patients and their family members or other individuals financially responsible ("guarantors") 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. Financial Counselors serve as guides to patients and guarantors (collectively referred to as "patients" in the remainder of this policy) 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, including 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 within VHS guidelines for those who do not qualify for Financial Assistance or any other program and those who have a financial responsibility after the FAP review. Financial Assistance is the financing option of last resort. As such, Financial Assistance applicants are expected to comply with the screening and application processes of any local, state, or federal programs that would cover the cost of the same medical care, including traveler health programs or any organizational programs, such as those administered by foreign governments or international organizations/corporations for affiliated persons. 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 who have a combined family income up to 200% or less of the Federal Poverty Level (FPL). For families with incomes above 300%, up to 500% of FPL, with medical debt exceeding $25,000, Catastrophic Financial Assistance discounts limit medical debt to 30% of income or the Amounts Generally Billed (AGB) billed to insured individuals, whichever is less. Please see the full FAP and explanation of how AGB and partial discounts are calculated, as well as the current AGB rate. 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, permanent U.S. residents, and individuals who intend to stay in the U.S. as permanent residents are eligible for Financial Assistance. Patients/Guarantors who do not intend to remain permanently in the U.S., or are in the U.S. on a student visa or tourist visa are not eligible for VHS Financial Assistance. Regardless of residency status, all patients are expected comply with the screening and application processes of any local, state (any eligible state programs, whether the state of patient's current location or permanent residence), or federal programs that would cover the cost of the same medical care, including traveler health programs or any organizational programs, such as those administered by foreign governments or international organizations/corporations for affiliated persons.

HOW TO APPLY:

Patients and caregivers are encouraged to contact:

- VHS Financial Counselors by **phone at 866-414-4576**, or **e-mail to: PBDValleyHealth@ensemblehp.com** at the earliest possible opportunity.

- The VHS Financial Assistance Application can be found online at http://www.valleyhealthlink.com/charitycare. 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 Financial Counseling assistance, including help with applications and billing questions, is available from 8:00 am to 4:30 pm, Monday through Friday, except holidays, in our **Customer Service Center** located in Suite 100 of the VHS System Support Building (SSB) directly off of the main lobby:

Customer Service Center 220
Campus Blvd, Suite 100
Winchester, VA 22601

All other in person Financial Counseling locations in other Valley Health System facilities remain closed at this time due to the COVID-19 Pandemic. The Customer Service Center in the SSB has been constructed to allow greater distancing, including glass partitions and other safeguards to promote the safety of our visitors and employees. Other in person locations will be re-opened as circumstances permit.

End of Plain Language Summary.

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RETURN APPLICATION TO :

P.O. Box 3340, Winchester, Virginia 22604 –2540 OR Fax to: 513-964-3190, OR e-mail to:

PBDValleyHealth@ensemblehp.com Phone # 866 – 414 - 4576

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 household members, 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: ( ) _____

Continued on next page

EMPLOYMENT, INCOME, AND ASSETS INFORMATION:

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. (attach an additional page if necessary)

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

Continued on next page

II. Monthly Household Expenses

Expense	Monthly $	Expense	Monthly $
Food		Electricity	
Car/Transportation Expenses		Water	
Auto Insurance		Phone (Land & Cell)	
Health Insurance		Gas(Heating/Propane)	
Life Insurance		Cable	
Home Owners Ins (if not included in Mortgage or Rent Payment)		Medicine	
Other (Explain)		Other (Explain)	

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)			

Continued on next page

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.

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)

Continued on next page

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.

The undersigned certify that all statements made in this application 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 _____

Continued on next page

CASE NAME _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize the following information to be released to Alysha Clark, Shannon Nuckles, Teresa Moffatt, Chelsea Manley, Pam Runion 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

Alysha Clark, Shannon Nuckles, Teresa Moffatt,v Chelsea Manley, Pam Runion, 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