Date: __________________

Dear Guarantor,

We have enclosed the following three items for your completion:

- A Notice of Availability of Financial Assistance Program
- Instructions for applying for Financial Assistance Program
- An Application for our Financial Assistance Program

Please read the first item – the Notice of Availability of Financial Assistance. After reading this, if you believe that you would qualify for our financial assistance program, please proceed to the second item – the instructions for completing the Financial Assistance Program application. Please read these instructions carefully and refer back to it as needed to complete the application in its entirety.

We must receive this completed application and all required documents within 14 days of the above date. Send the application along with a copy of all required documents that apply to your family/household unit to this address:

Northwest Medical Center
ATTN: FINANCIAL SERVICES OFFICE
1530 U.S. Highway 43
Winfield, AL 35594

If you need help completing your application and would like to speak with our Financial Counselor, or if you would like to make an appointment to come in and speak with someone in person, please call (205) 487-7710.

Sincerely,

Christina Burgess
Director of Patient Financial Services
Northwest Medical Center

Notice of Availability of Financial Assistance

As a community service, Northwest Medical Center will give a reasonable amount of its services without charge or at a reduced charge to eligible persons who cannot afford to pay for care.

To be eligible for Financial Assistance, your annual family income must be at or below the following levels:

Size of Family	Poverty Guidelines
1	$19,140
2	$25,860
3	$32,580
4	$39,300
5	$46,020
6	$52,740
7	$59,460
8	$66,180

For each additional family member add $6,090.
Maximum liability for anyone who qualifies will be 20% of annual income.
The above information is based on 150% of the 2020 Federal Poverty Guidelines.

Your bill may also be reduced if your income is above these levels, if you meet certain guidelines.

If you think you may be eligible for Northwest Medical Center's Financial Assistance Program, you may complete the application and submit all requested documentation. If you need assistance with this, please call (205) 487-7710.

Northwest Medical Center will make a written conditional or final determination of your eligibility for financial assistance for urgent, emergent, or inpatient services within 30 working days of your completed request.

Instructions for completing Financial Assistance Application

In order for the Business Office to evaluate you for our financial assistance program, please return the requested information within 14 days so that we may process your application.
We must receive all required information below:

- The completed Financial Assistance Application
- Proof of last 12 month's gross income for each employed person in family/household unit.
  - Most recently signed federal income tax form, complete with a copy of W-2(s), 1099, etc. If you did not file taxes verification of non-filing from the IRS is required. (IRS - 1-800-829-1040)
  - Proof of Social Security income, if applicable. We will need a copy of direct deposit to bank account, or a check stub or letter which states the monthly income for the year.
  - Copies of last three (3) pay stubs for each employed person in family unit. Stub should show year-to-date (YTD) gross income for proof of income. Or, if you or family member are paid in cash, we will need a written statement from the employer that has been notarized or is on company letterhead verifying gross income. Must be signed by employer, must have phone number of employer. This information will remain confidential.
  - Copies of two most recent bank statements
  - Proof of alimony, child support, unemployment, pension, etc.
- If you receive no income, and are being supported by relatives or friends, a notarized letter explaining those arrangements is required. The letter must be signed by person(s) lending assistance.
- If you, your spouse, or anyone of working age living with you is unemployed, a notarized letter is also required stating length of unemployment, along with the name and relationship to you.
- If you or anyone in your household receives food stamps, a verification letter is required.
- Proof of non-eligibility for Medicaid, if a Medicaid application was submitted to the state.

Once you have completed the enclosed application and collected all the items listed, please mail the documents in the envelope provided to:

Northwest Medical Center
ATTN: FINANCIAL COUNSELOR
1530 U.S. Highway 43
Winfield, AL 35594

If you need any help completing the application or have any questions about the items requested, please call our Financial Counselor at (205) 487-7710.

Financial Assistance Application (Page 1 of 5)

*Please Print and use ink   Date: _______________

1. PATIENT INFORMATION

Account #: ______________________   Social Security Number: ___________________

Name: ____ D/O/B: _______/ _________ / _______
(Last)   (First)   (MI)   (MM/DD/YY)

Present Address: ____
(Street)/Apt Number)   (City)   (State)   (Zip)

Previous Address: ____
(Street)/Apt Number)   (City)   (State)   (Zip)

Telephone Number: (___) __________________ (_____) ________________ (____) _____________
(Home)   (Work)   (Cell)

2. RESPONSIBLE PARTY INFORMATION

Name: ____ D/O/B: _______/ _________ / _______
(Last)   (First)   (MI)   (MM/DD/YY)

Present Address: ____
(Street)/Apt Number)   (City)   (State)   (Zip)

Previous Address: ____
(Street)/Apt Number)   (City)   (State)   (Zip)

Telephone Number: (___) __________________ (_____) ________________ (____) _____________
(Home)   (Work)   (Cell)

Relationship to Patient: ___________________________ Social Security Number: __________________

3. List all persons residing in household:

	Name	Age	Disabled?	Annual Income
Head of House	____________________________	________	Y/N	________________
Spouse	____________________________	________	Y/N	________________
Child	____________________________	________	Y/N	________________
Child	____________________________	________	Y/N	________________
Child	____________________________	________	Y/N	________________
Child	____________________________	________	Y/N	________________
Child	____________________________	________	Y/N	________________
Child	____________________________	________	Y/N	________________
Other Dependents:	____________________________	________	Y/N	________________

 Name: ____________________________________
(Last) (First) (MI)

4. Insurance Information:

Do you have health insurance? If so, list below:

	Insurance Company	Policy #	Group #
1.	______________________	______________	____________
2.	______________________	______________	____________
3.	______________________	______________	____________

Is health insurance available to you through your employer? Yes _______ No _________

Have you declined health insurance coverage offered to you by your employer or through the responsible person's employer? Yes________ No ________

Have you received or do you expect to receive a Third Party Liability settlement related to an accident or injury resulting in your admission to the Hospital? Yes _______ No ________

If your admission is the result of an accident or injury, are you represented by an attorney? Yes _______ No_______ If yes, please complete the following information:

Attorney name: ____

Attorney Address: ____

____

____

Attorney telephone: ____

Are you eligible to apply for the Affordable Care Act health insurance coverage? Yes______ No _______

If yes, what was the outcome? Provide insurance information or other outcome.
____

If no, why are you not eligible to apply? ____

Financial Assistance Application (Page 3 of 5) Name: ______________________
(Last) (First) (MI)

5. Income / Expenses

DESCRIPTION	MONTHLY INCOME
List monthly income from any source	
A. GROSS SALARY for husband	$ ________
NET SALARY for husband	$ ________
EMPLOYER NAME ________	
EMPLOYER PHONE: ________	
B. GROSS SALARY for wife	$ ________
NET SALARY for wife	$ ________
EMPLOYER NAME ________	
EMPLOYER PHONE: ________	
C. DIVIDENT AND INTEREST	$ ________
D. RENTAL INCOME	$ ________
E. PENSION INCOME	$ ________
F. CHILD SUPPORT (INCOME)	$ ________
G. ALIMONY (INCOME)	$ ________
H. ADDIITONAL INCOME	$ ________
I. SOCIAL SECURITY BENEFITS	$ ________
J. V.A. BENEFITS	$ ________
K. WELFARE	$ ________
L. OTHERS – LIST	$ ________
	$ ________
	$ ________
Total Income Per Month	$ ________

DESCRIPTION	MONTHLY EXPENSE
A. RENT/HOUSE PAYMENT	$________
B. FOOD	$________
C. UTILITIES…………………… (Elect/Water/Phone/Gas)	$________
D. REPAIRS (Car or Home)	$________
E. INSTALLMENT LOANS-List	$________
________	$________
________	$________
F. CAR PAYMENT	$________
G. OTHER CHARGE ACCOUNTS	$________
H. CREDIT CARD ACCOUNTS	$________
I. CELL PHONE	$________
J. CABLE/SATELLITE TV	$________
K. CHILD SUPPORT	$________
L. ALIMONY	$________
M. CHILD CARE	$________
N. MEDICAL TRANSPORTATION	$________
O. EDUCATION (Students Only)	$________
P. MONTHLY MEDICATION(S)	$________
Total Expenses Per Month	$________

ASSETS

DESCRIPTION	VALUE AMOUNT
A. CHECKING ACCOUNT	$ ________
BANK NAME ________	
B. SAVINGS ACCOUNT	$ ________
BANK NAME ________	
C. IRS	$ ________
D. INSURANCE POLICY	$ ________
E. HOME	$ ________
Total Assets	$ ________

DESCRIPTION	VALUE AMOUNT
F. CAR	$ ________
G. OTHER ASSETS – List	$ ________
________	$ ________
________	$ ________
________	$ ________
________	$ ________

[signature page to follow]

Financial Assistance Application (Page 4 of 5) Name: ___________________________________
(Last) (First) (MI)

I understand that the information I submit is subject to verification by the Hospital Business Office and subject to review by state and/or federal enforcement agencies and others as required, and my signature authorizes my employer to certify the information provided in this application. I also authorize Hospital to request reports from credit reporting agencies and the Social Security Administration.

I am consenting to financial assistance administrative services for __________ ______________.
(Patient name)

I certify under the statutes of perjury that the information on these pages is true and correct, and that I do not have the financial means to pay for medical care rendered to the above patient.

If my financial situation changes in the upcoming calendar year, I will report these changes to the Hospital Business office immediately.

My signature on this application verifies that if I am entitled to any other medical benefits, including, but not limited to, a supplemental insurance policy, that I will provide the Hospital Business Office with this information. Should I choose not to give any information regarding my supplemental insurance carrier, my application for assistance may be denied and I may be responsible for the total amount of the bills.

*Financial assistance does not include medication and other services or devices that are not medically necessary.

Signature of Patient or Guarantor: ______________________________ Date signed: __________

Please return to:

Northwest Medical Center
ATTN: FINANCIAL COUNSELOR
1530 U.S. Highway 43
Winfield, AL 35594

Financial Assistance Application (Page 5 of 5)   Name: ____________________________________
(Last)   (First)   (MI)

Please answer the following questions:

Are you currently on dialysis for kidney disease?   Yes ________ No ________

Are you a kidney transplant patient?   Yes ________ No ________

Charity Care and discounted care does NOT cover the following services:

- Reconstructive surgery
- Cosmetic surgery
- Breast implants
- Breast reduction
- Teeth extractions, excluding radiation or transplant patients
- Dentures
- Treatment for infertility
- Medications
- Durable medical equipment
- Services not normally covered by health insurance
- Services that have been determined non-urgent by physician

This is an example of services not covered under the Charity Care/Financial Assistance program. This list may not include all exclusions to the program.

Should you have any questions regarding your particular plan of care, please fee free to call our office.

We reserve the right to change or update covered or non-covered services without notice.

My signature below verifies that I have read and understand the list and statements above.

Signature ____ Date ___________________
Patient or Guarantor

****Please do not write below this line, office use only****

Reviewed by: ____ Date ___________________

Approval Signature: ____________________________________ Date ___________________

Denial Signature: ______________________________________ Date ___________________

***** If you need help with the application, please call (205) 487-7710 *****