LMHHealth

A partner for lifelong health

Financial Assistance Program & Application

2019 Program Guidelines

Consistent with its mission to provide high quality health and wellness services for the community, Lawrence Memorial Hospital (LMH) is committed to providing financial assistance to individuals in need of medically necessary treatment who are unable to pay.

Eligibility

- All patients presenting with emergent or urgent needs for which services are offered by LMH will be eligible to apply for financial assistance.
- Patients who need medically necessary elective services will be eligible to apply for financial assistance if they are residents of the LMH service area.
- Financial assistance is not available for services generally deemed cosmetic.
- All applicants are required to apply for any available assistance (including but not limited to Medicare, Medicaid, Veterans Administration, private health insurance, copayment assistance, pharmaceutical assistance programs, medical device assistance programs, etc.) which may be available for payment of services and will take any action reasonably necessary to obtain such assistance.
- Accounts for which legal action have been taken are not eligible.

Required Documentation

The following documentation is required in order for the application to be processed. If supporting documentation is not provided within 30 days, the application will be denied.

Required documentation includes:

- ☐ Proof of *Gross Monthly* income (most recent two month's paycheck stubs).
  ** If you are unemployed, proof of whatever income source you have from which you pay rent, utilities, etc.)
- ☐ Proof of Spousal Support / Alimony / Child Support received.
- ☐ Proof of Social Security / Disability / Unemployment received / Food Stamps.
- ☐ Letter of Support from an individual assisting you with room/board, food, etc.
- ☐ Proof of Pension, Rental Income, Other Income.
- ☐ Proof of Student status.
- ☐ Current detailed bank statement(s) for Checking and Savings accounts for last three months.
- ☐ Most recent Federal Tax Return (copy of your 1040, 1040A or 1040EZ and schedules).
- ☐ W2 / 1099 Forms.

Federal Poverty Guidelines

LMH utilizes a sliding scale based on the Federal Poverty Guidelines, as published in the Federal Register as the basis for approval of applications. The current guidelines can be found online at: https://www.federalregister.gov/documents/2019/01/19/2019-00814/annual-update-of-the-hhs-poverty-guidelines

Participating Providers

This is a list of physician practices associated with LMH, which will honor your financial assistance discount:

Lawrence Memorial Hospital

Primary Care

- Eudora Family Care
- Family Medicine of Baldwin City
- Family Medicine of Tonganoxie
- McLouth Medical Clinic
- Mt. Oread Family Practice
- Reed Internal Medicine
- The Internal Medicine Group
- Total Family Care

Non-LMH Affiliated Practices

- Lawrence Cancer Center
- Lawrence Clinical Laboratory

Specialty Care

- Cardiovascular Specialists of Lawrence
- Lawrence Endocrinology
- Lawrence General Surgery
- Lawrence GI Consultants
- Lawrence Neurology Specialists
- Lawrence OB-GYN Specialists
- Lawrence Pulmonary Specialists
- Lawrence Spine Care
- Lawrence Urology Specialists
- Lawrence Vein Center
- LMH Oncology / Hematology Center
- LMH Psychiatric Consultation Service
- LMH Wound Healing Center
- LMH Hospitalists
- OrthoKansas
- Plastic Surgery Specialists of Lawrence

Our Financial Counselors

If you have any questions concerning this application or the process, please contact your Financial Counselor below:

Last Name Starts With	Financial Counselor	Phone Number
A - M	Cory	(785) 505-5781
N - Z	Dave	(785) 505-5782

Complete applications will be processed in approximately 30 business days after receipt of completed application and all required documentation. You will receive an approval or denial letter in the mail.

Please return completed application and documents to:

Lawrence Memorial Hospital – Patient Financial Services
Attn.: Financial Counselors
325 Maine Street
Lawrence, KS 66044

LMHHealth

RECEIVED:

APPLICATION FOR FINANCIAL ASSISTANCE

Patient Name / Responsible Party / Guarantor's Information ***					
Last Name:		First Name:		M.I.	Date of Birth:
Address:		City:		State:	Zip Code:
Employer:		Social Security No.:		Telephone No.: ( )	
Employer's Telephone No.: ( )	Full-Time:	Part-Time:	Hours per Week:	Hourly Wage: $	☐ Weekly ☐ Bi-Weekly ☐ Monthly

Spouse's Information					
Last Name:		First Name:		M.I.	Date of Birth:
Address:		City:		State:	Zip Code:
Employer:		Social Security No.:		Telephone No.: ( )	
Employer's Telephone No.: ( )	Full-Time:	Part-Time:	Hours per Week:	Hourly Wage: $	☐ Weekly ☐ Bi-Weekly ☐ Monthly

Please list all dependents (those individuals claimed on your tax return, please do not list individuals listed above).

Dependent's Name	Social Security No.	Date of Birth	Relationship to Guarantor

Cash on Hand – please provide your current balance(s). Please attach copies of your bank statements to support.

Type of Account	Guarantor	Spouse
Checking / Savings	$	$
Investment Accounts	$	$
Other	$	$

***** Responsible party / guarantor will typically be the patient, unless the patient is a minor.**

Continue to Next Page

Provide gross income details (prior to deductions) for guarantor and spouse. PLEASE ATTACH ALL DOCUMENTATION.				
Source of Income	**Guarantor (Monthly)**	**Spouse (Monthly)**	**Other (Monthly)**	**Total (Monthly)**
Wages or Self-Employment	$	$	$	$
Public Assistance (Food Stamps)	$	$	$	$
Social Security / Disability	$	$	$	$
Unemployment / Worker's Comp.	$	$	$	$
Child Support (Received)	$	$	$	$
Pensions	$	$	$	$
Other:	$	$	$	$
Total Monthly Income:	$	$	$	$
Total Yearly Income:			**$**	

I understand this application is made for evaluation of financial assistance based on the Financial Assistance Policy of Lawrence Memorial Hospital. I certify that the above information is true and accurate to the best of my knowledge. ***Further, I agree that my information may be screened for public assistance (Medicaid, Medicare, Insurance, etc.) and I will take any action reasonably necessary to obtain such assistance.*** I agree to have any information shared with other medical providers associated with Lawrence Memorial Hospital. If any information I have given proves to be untrue, I understand that my application will be denied. I further understand, that I must continue making payments on my account(s) while this application is being processed.

Responsible Party / Guarantor's Signature	Date	Spouse's Signature	Date

Financial Counselor's Recommendation			
Hospital Current: $	**Hospital Bad-Debt:** $	**Physician Current:** $	**Physician Bad-Debt:** $
Patient/Dependent Status: Insured: ☐ Un-Insured: ☐	**Patient/Dependent Ins.:**	**Total Balance:** $	
Req. Documents Received: Yes: ☐ No: ☐		**Referred to Medicaid Vendor:** Yes: ☐ No: ☐	**Compliant with PB Screening:** Yes: ☐ No: ☐
List Additional Documentation Needed:			
Monthly Income: $	**Family Size:**	**% of FIPG:** %	**Bills % of Ann. Gross Income:** %
Recommendation: Approved: ☐ Denied: ☐	**Discount:** ☐ 25% ☐ 50% ☐ 75% ☐ 100% ☐ 100% w/ Svc. Fees	**Denial Reason:** ☐ Out of Service Area ☐ Over Income ☐ Non-Compliant with PB Screen ☐ Missing Documentation	
Comments/Notes:			
Financial Counselor's Approval:		**Supervisor/Manager/Sr. Director Approval:**	
Scan to Account No.:		**Vice President/CFO Approval:**	