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ATTACHMENT A

CHARITY CARE AND FINANCIAL ASSISTANCE APPLICATION

KidsPeace provides medically necessary services to patients regardless of their ability to pay. It is the responsibility of the patient's family to apply for any state or federal financial assistance program. Should a family not qualify for State or Federal programs, KidsPeace will assess any family that is uninsured or underinsured based on gross income, documented hardships and family size to consider reduced financial responsibility.

Instructions: Please complete the form in its entirety. All copies of supporting documentation should be attached to avoid processing delay. An application cannot be processed unless all documentation is received.

Patient Demographics:

Patient Name: _____ **Patient Date of Birth**_____

Guarantor/Parent Information

1. Guarantor/Parent Name _____**Date of Birth:** _____

Guarantor/Parent Social Security # _____

Relationship to Patient: _____ **Employer:** _____

Full Address: _____ **Home**

Phone: _____ **Cell Phone:**_____

2. Guarantor/Parent Name _____**Date of Birth:** _____

Guarantor/Parent Social Security # _____

Relationship to Patient: _____ **Employer:** _____

Full Address: _____ **Home**

Phone: _____ **Cell Phone:**_____

Size of Family _____ **First Names of all Family Members:** _____

Please circle all forms of income received within the last six months:

Wages	**Pension**	**Unemployment Compensation**	**Social Security**
Child Support	**Alimony**	**Disability Benefits**	**Workers Compensation**
Public Assistance	**Net Rental Income**	**Annuities**	**Interest income**
Child Support	**Other**		

Please attach supporting documentation for any of the above income categories that apply for the most recent six month period.

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Banking Institutions: _____ / _____ / _____
Name **Checking Acct #** **Savings Acct. #**

_____ / _____ / _____
Name **Checking Acct #** **Savings Acct. #**

The undersigned hereby authorizes any bank, loan institution, insurance company, employer, or any creditor whatsoever of the undersigned to release any information requested by KidsPeace, Inc. pertaining to any and all financial matters involving or related to the patient and family.

By signing this, you are attesting that all of the information provided is true and correct.

Date: _____ _____

Responsible Party Signature

Date: _____ _____

Responsible Party Signature

To Be Completed By KidsPeace Business Office

Patient Account Number(s):_____

Date Received:	All Documentation YES/NO
Date More Information Requested:	Date More Information Received:
Date Processed:	Initials of Processor:
Total Monthly Income:	Approved / Not Approved
Sliding Fee Reduced Cost:	Effective:
Processor Approval Signature:	Date:
Manager Approval Signature:	Date:
CFO Approval Signature: (if needed)	Date SMS Rate Updated:
Date Notification Sent:	Date SMS Note Added:

Notes:_____

_____

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Attachment B

Federal Poverty Guidelines
Sliding Fee Scale
Effective November 2015

Size of Family Unit	100% 100% Discount 0% Pay	101% - 133% 80% Discount 20% Pay	133% - 200% 60% Discount 40% Pay	201% - 300% 40% Discount 60% Pay	301% - 400% 20% Discount 80% Pay	401% 0% Discount 100% Pay
1	$ - - $ 11,770.00	$ 11,771.00 - $ 15,654.00	$ 15,655.00 - $ 23,540.00	$ 23,541.00 - $ 35,310.00	$ 35,311.00 - $ 47,080.00	Over $ 47,081.00
2	$ - - $ 15,930.00	$ 15,931.00 - $ 21,187.00	$ 21,188.00 - $ 31,860.00	$ 31,861.00 - $ 47,790.00	$ 47,791.00 - $ 63,720.00	Over $ 63,721.00
3	$ - - $ 20,090.00	$ 20,091.00 - $ 26,720.00	$ 26,721.00 - $ 40,180.00	$ 40,181.00 - $ 60,270.00	$ 60,271.00 - $ 80,360.00	Over $ 80,361.00
4	$ - - $ 24,250.00	$ 24,251.00 - $ 32,253.00	$ 32,254.00 - $ 48,500.00	$ 48,501.00 - $ 72,750.00	$ 72,751.00 - $ 97,000.00	Over $ 97,001.00
5	$ - - $ 28,410.00	$ 28,411.00 - $ 37,785.00	$ 37,786.00 - $ 56,820.00	$ 56,821.00 - $ 85,230.00	$ 85,231.00 - $ 113,640.00	Over $ 113,641.00
6	$ - - $ 32,570.00	$ 32,571.00 - $ 43,318.00	$ 43,319.00 - $ 65,140.00	$ 65,141.00 - $ 97,710.00	$ 97,711.00 - $ 130,280.00	Over $ 130,281.00
7	$ - - $ 36,730.00	$ 36,731.00 - $ 48,851.00	$ 48,852.00 - $ 73,460.00	$ 73,461.00 - $ 110,190.00	$ 110,191.00 - $ 146,920.00	Over $ 146,921.00
8	$ - - $ 40,890.00	$ 40,891.00 - $ 54,384.00	$ 54,385.00 - $ 81,780.00	$ 81,781.00 - $ 122,670.00	$ 122,671.00 - $ 163,560.00	Over $ 163,561.00
Each Addt'l member	$4,160	$5,200	$6,240	$7,280	$8,320	$ 8,321.00

4085 Independence Drive
Schnecksville, PA 18078

800-25-PEACE

www.kidspeace.org

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ATTACHMENT C

(DATE)

(APPLICANT)
(ADDRESS-LINE ONE)
(CITY, STATE, POSTAL ZIP CODE)

RE: DETERMINATION NOTICE FOR REDUCED COST OF CARE
(CLIENT NAME) (PATIENT ACCOUNT NUMBER)
(DATES OF SERVICE)

Dear Mr. /Mrs. /Ms. (APPLICANT'S LAST NAME);

We have processed your application for reduced/waived costs.

At this time your application has been:

☐ APPROVED.

Your approved waived amount is _____%.

☐ DENIED.

You were denied because your gross income exceeded 400% of the Federal Poverty Guidelines published at time of application. We calculated your total household gross annual income at $_____ for a family size of ____. Based on the guidelines a family size of ____ must not exceed 400% or $_____. If you feel this information is not correct, you are welcome to appeal the decision. If you have additional questions, please contact Gerard Gleeson at 610-799-8038.

Sincerely,

(KIDSPEACE EMPLOYEE NAME)
(KIDSPEACE EMPLOYEE TITLE)

4085 Independence Drive
Schnecksville, PA 18078
610-799-8000
610-799-8318
800-25-PEACE
www.kidspeace.org

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Dear Parent/Guardian:

KidsPeace is committed to providing excellent care regardless of a family's ability to pay. We recognize that this can be a difficult and trying time not only for the child but also for the family. You are receiving this packet because you indicated a financial hardship exists with paying your medical bills.

Attached please find our Charity Care Application. All completed applications are processed in confidence and are screened without prejudice and discrimination. Based on the information provided, you may qualify to be partially forgiven or fully forgiven of the amount outstanding. If your child is in care for an extended period of time, we request this process to be completed every six months to ensure your financial situation has not changed.

Before we can process your application you must attach supporting documentation showing **all income sources for everyone in your household** for the last six months. Instructions are detailed on the application. For your convenience, a checklist of items needed is provided below. Any missing information will delay the application process.

_____**Application- completed to its entirety, signed, dated**
_____**Copies of all income- for the last 6 months, including but not limited to:**
- _____**Paystubs (if self employed provide your most recent year's tax return)**
- _____**Child support printouts**
- _____**Alimony paystubs/printouts**
- _____**Pension paystubs/printouts**
- _____**Military Benefits paystubs/printouts**
- _____**Unemployment paystubs/printouts**
- _____**Social Security Income (SSI) paystubs/printouts**
- _____**Disability Benefits paystubs/printouts**
- _____**Workers Compensation paystubs/printouts**
- _____**Public assistance documentation (cash, food stamps, etc)**
- _____**Net Rental Income**
- _____**Annuities**
- _____**Interest Income**
- _____ **Other- any other source not listed here**

Additionally, if there is a significant financial hardship that you are currently facing, you are welcome to include any supporting documentation with your application, but it is not a requirement to process the application.

If you have any questions, please contact me directly at Kathryn.Sena@kidspeace.org or 610-799-8549. Once we have your complete application, we will process it and make a determination within 7 business days. Regardless of the decision, you will be notified.

Sincerely,

Kathryn Sena
Manager, KidsPeace Patient Accounts Department