Springfield Nephrology Associates

1911 S National Ave. Suite 301 Springfield, MO 65804

Giselle Kohler, MD
Ethan Hoerschgen, MD
David L. Sommerfeld, MD
Susan A. Woody, DO
Kristie E. Jones, MD

Dear Springfield Nephrology Patient,

Springfield Nephrology Associates, Inc. (hereinafter SNA) has modified the financial assistance program to accommodate patients during hard economic times. The purpose is to ensure that all patients have an equal opportunity to address his or her account balance within the confines of the household income.

The financial assistance packet is enclosed with instructions on how to fill out the application. To ensure that your application is expedited in a timely manner, please read the instructions, and submit the appropriate documentation with your application. Neglecting to do so will result in a delay in evaluating your financial situation.

Our financial assistance program is on a sliding scale in accordance with Federal Poverty Guidelines (FPG). Qualified applicants will receive a discount ranging from 10%-100% of the outstanding balance. All applicants will receive notification of approval or denial within 30-days of receipt of the completed application.

All patients who qualify for financial assistance ranging from 10%-90% will be expected to maintain a current payment plan for the outstanding balance. Upon paying your patient portion of the bill, SNA will adjust the remaining balance. Any delinquent payment, or breach in our mutual payment arrangement, will result in SNA rescinding the financial assistance agreement and the full account balance will become due and payable.

Complete the enclosed application and return to us by mail, by fax or myChart. Please contact us if you have any questions and/or concerns regarding this packet. Our office hours are Monday-Friday between 8:00AM - 4:30PM.

Respectfully,

Billing Department
Springfield Nephrology Associates, Inc.
417-886-5000
admin@springfieldnephrology.com

Enclosures: Financial Packet

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Reasons for Denial

1. **Information Falsification**- SNA will deny a Financial Assistance Application before/after a patient is granted assistance if the patient or responsible party intentionally provides false information relating to any aspect of the application that might indicate a financial means to pay for care.
2. **Incomplete Application**- SNA will deny incomplete applications. This includes but is not limited to: lack of requested documentation, incomplete fields, or illegible writing.

Understanding Financial Options that may be available

Financially Indigent- This means an uninsured or underinsured patient whose total reported income is less than or equal to 130% of the Federal Poverty Guidelines (FPG). These financially indigent patients are eligible for a 100% discount.

Financial Review Clarification- Dependents definition for calculation of family members- This includes any immediate family member that resides in the same residence as the patient. According to IRS regulations, for someone to be considered a dependent on another individual's tax return, over one-half of the dependent's total support for that year must have been furnished by the taxpayer and the dependent must have less than $3,200 of gross income for the most recent tax year, unless they are under 19 (or 24 and a full-time student.) Additionally, if someone in the household is not an immediate family member, then SNA defers to local law regarding the dependence classification.

Immediate Family Definition: step-children (minor or adult), grandchildren, great grandchildren, siblings, half-siblings, step-siblings, step-parents, grandparents, nieces or nephews, aunts or uncles, son-in law or daughter-in-law, mother-in-law or father-in-law, brother-in-law or sister-in-law.

Reservation of Rights- SNA reserves the right to limit or deny financial assistance to patients at the sole discretion of SNA.

Income Indicators- IRS W-2, Wages and Tax Statement; pay check remittance; individual tax return; bank statements; Social Security payment remittance, Worker's Compensation payment remittance; unemployment insurance payment notice; Unemployment Compensation Determination Letters; or other appropriate indicators of the patient's reported income.

**A copy of last year's tax return will suffice for Income and Dependents proof.

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SPRINGFIELD NEPHROLOGY ASSOCIATES, INC.

FINANCIAL HARDSHIP FORM

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY. An incomplete application cannot be processed.

Check the appropriate response to complete the following statements:

I, _____:
(Print applicant's name)

DO	DON'T	
☐	☐	Have a checking account (current copy required)
☐	☐	Have a savings account (current copy required)
☐	☐	Receive food stamps (approval letter required)
☐	☐	Receive subsidized housing benefits (copy of contract required)
☐	☐	File a federal tax return for the previous year (copy of most recent tax return and all schedules required).
☐	☐	Have a disability claim or an appeal pending (provide current proof of claim pending or appeal letter).
☐	☐	Receive child support or alimony
☐	☐	Currently employed (copy of most recent pay stub).

_____ _____

Applicant's Signature Date

COPIES OF DOCUMENTS MUST BE SUBMITTED WITH APPLICATION OF ALL THAT APPLY.

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Springfield Nephrology Associates, Inc.
Application for Financial Assistance

Please Print

Patient First Name	M.I.	Last Name	Date of Birth

Name of Person Responsible for the Patient's Balance	Phone Number for Financial POA

Detailed Patient Information

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Marital Status: _____ Social Security Number (required) _____

Email: _____

Employer Name: _____ Phone: _____

If not working, when was your last date of employment? _____

Number of dependents (including 1 for yourself & 1 for spouse): _____

-Include proof

Have you applied for Medicaid? Y / N If so, when? _____

Are you a dialysis patient? Y / N

Are you interested in receiving information regarding a personal loan for your outstanding balance? Y / N

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Detailed Insurance Information:

Insurance Policy 1:		
	Name of Policy	Policy Number:
	Deductible Amount	Co-pay/co-insurance amount
Insurance Policy 2:		
	Name of Policy	Policy Number:
	Deductible Amount	Co-pay/co-insurance amount
Insurance Policy 3:		
	Name of Policy	Policy Number:
	Deductible Amount	Co-pay/co-insurance amount

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Detail Financial Information

(This information is regarding **everyone** residing with the patient that is claimed as dependent.)

*****PROOF MUST BE INCLUDED**

		Monthly Income		Monthly Expenses
Employment:	Patient:	$	Rent/Mortgage:	$
	Spouse:	$	Utilities:	$
	Other:	$	Food:	$
Retirement:	Social Security:	$	Health Insurance:	$
(Patient & Spouse)	VA Pension	$	Home Insurance:	$
	Employee Pension	$	Car Insurance:	$
Other Income:	Alimony:	$	Medical Payments:	$
(All Adults claimed as Dependents)	Child Support:	$	Auto Payments:	$
	Investments:	$	Credit Card Debt:	$
	Public Assistance:	$	Agriculture:	$
	Work Comp:	$	Livestock:	$
	Unemployment:	$	Transportation:	$
	Disability:	$	Medicine:	$
	Insurance:	$	Medical Supplies:	$
	Savings:	$	Home Phone:	$
	Agriculture:	$	Cell Phone(s):	$
	Livestock Sales:	$	Life Insurance:	$
	Interest:	$	Clothing:	$
	Life Insurance:	$	Personal Loans:	$
	Other Business:	$	Other Expenses:	
	Rental Property:	$		$
	Total	$		$
				$
				$
				$

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Assets: (If more space is needed, please attach separate sheet)

Include- Stocks, Bonds, CDs, Property, Boat(s), Business, Motorcycles, RV, Trailers, Timeshares, etc.

_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____
_____ $ _____

Bank account information: **Average Balance**

Checking Account 1: $ _____
Checking Account 2: $ _____
Savings Account 1: $ _____
Savings Account 2: $ _____

Are you a homeowner? Y / N

Dwelling 1: Approx. Value $ _____ Approx. Balance on Mortgage $ _____ Monthly Payment $ _____

Dwelling 2: Approx. Value $ _____ Approx. Balance on Mortgage $ _____ Monthly Payment $ _____

Do you own a car(s)? Y / N

Car 1: Approx. Value $ _____ Approx. Balance on Loan $ _____ Monthly Payment $ _____

Car 2: Approx. Value $ _____ Approx. Balance on Loan $ _____ Monthly Payment $ _____

Have you ever filed for bankruptcy? Y / N If so, when? _____

Has any of your property been foreclosed on? Y / N If so, when? _____

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Please state what type of assistance you are receiving/applying for from other agencies. Provide name of agency, phone number, and contact person.

1 _____

2 _____

I, the undersigned, do hereby certify that I have read or had read to me all of the statements on this application and that the information I have provided is true and accurate to the best of my knowledge and agree to report any changes.

I further authorize the release of any information, including financial information, needed to determine my eligibility for the SNA Financial Assistance Program. I understand and hereby further authorize SNA, their affiliates, their collection agencies or attorneys to verify the information contained in the application, including obtaining and reviewing my credit reports or that of the patient, guarantor and/or responsible party.

I understand that my eligibility for a discount will expire after one (1) year and that I must reapply to continue to receive applicable discounts. I understand that the discount approval does NOT cover any visit lab fees and would only apply to any patient balance after insurance. I also understand that any discount may be withdrawn should my financial condition change.

_____ _____

Signature Date