Wyoming Cardiopulmonary Services, P.C.

Healthcare Assistance Application (2024)

For those individuals who qualify as “medically indigent patients”, ie, those with no or inadequate means of paying for needed care under current methods of financing health care services, the following policy shall apply:

ELIGIBILITY CRITERIA:

CHARITY CARE IS SECONDARY TO ALL OTHER FINANCIAL RESOURCES AVAILABLE TO THE PATIENT, INCLUDING GROUP OR INDIVIDUAL MEDICAL PLANS, WORKERS’ COMPENSATION, MEDICARE, MEDICAID OR MEDICAL ASSISTANCE PROGRAMS, OTHER STATE, FEDERAL, OR MILITARY PROGRAMS, THIRD PARTY LIABILITY SITUATIONS (E.G., AUTO ACCIDENTS OR PERSONAL INJURIES), OR ANY OTHER SITUATION IN WHICH ANOTHER PERSON OR ENTITY MAY HAVE A LEGAL RESPONSIBILITY TO PAY FOR THE COSTS OF MEDICAL SERVICES.

In those instances where no primary payment sources are available, patients shall be considered for charity care under this policy based on the following criteria as calculated for the twelve (12) months prior to the date of the request:

1. The full amount of cardiology charges will be determined to be charity care for any patient whose gross family income is at or below 200% of the current federal poverty guidelines (as listed in Federal Register for current year).

2. The office may choose to grant charity care based solely on a request for such, received from any hospital served by the office, based solely on their evaluation of the patient’s financial need. In such cases, the office will not complete full verification or documentation of any request.

3. The office may also write off as charity care amounts for a patient with family income in excess of 200% of the federal poverty standard when circumstances indicate severe financial hardship or personal loss (ie, catastrophic charity care).

ELIGIBILITY DETERMINATION:

Charity care forms and instructions shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. All applications should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purposes of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;
2. Pay stubs from all employment during the 12 months prior to the date of request;
3. An income tax return from the most recently filed calendar year;
4. Forms approving or denying unemployment compensation; or
5. Written statements from employers or welfare agencies.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

Denials for charity care will be written and will include instructions for reconsideration. If additional verification/documentation of financial need is received to support charity care, the case will be reviewed and reconsidered per the above guidelines.

DOCUMENTATION & RECORDS:

1. Confidentiality: All information relating to the application will be kept confidential. Copies of the documents that support the application will be kept with the application form.

Federal Poverty Guidelines (as of January 2024)

Household	200% Poverty		250% Poverty	
Size	Annual	Month	Annual	Month
1	29,160	2,430	36,450	3,038
2	39,440	3,287	49,300	4,108
3	49,720	4,143	62,150	5,179
4	60,000	5,000	75,000	6,250
5	70,280	5,857	87,850	7,321
6	80,560	6,713	100,700	8,392
7	90,840	7,570	113,550	9,463
8	101,120	8,427	126,400	10,533

SOURCE: *Federal Register*
Federal Register January 1, 2024
https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

Wyoming Cardiopulmonary Services, P.C.

Please provide following information so we may complete your application:

- MOST RECENT IRS TAX FORMS (1040 AND W-2) (MUST BE SIGNED)
- CHECK STUBS FOR THE PAST 30 DAYS FOR ALL PERSONS EMPLOYED IN THE HOME.
- UNEMPLOYMENT CHECK STUBS FOR THE PAST 30 DAYS.
- DRIVERS LICENSE OR IDENTIFICATION CARD FOR ADULTS.
- PROOF OF ALL OTHER INCOME RECEIVED IN THE PAST 30 DAYS.
- ATTACHED FINANCIAL STATEMENT (**COMPLETELY FILLED OUT AND SIGNED**)

PLEASE BE SURE TO SIGN THE ATTACHED FINANCIAL STATEMENT
YOUR REQUEST WILL NOT BE PROCESSED IF THIS IS NOT SIGNED!

PLEASE RETURN ALL ITEMS ON THIS CHECKLIST (IN PERSON OR BY MAIL)

WYOMING CARDIOPULMONARY SERVICES
1230 EAST FIRST ST
PO BOX 51230
CASPER, WY 82605

Wyoming Cardiopulmonary Services, P.C.

FINANCIAL STATEMENT
PAYMENT PLAN/UNCOMPENSATED SERVICES APPLICATION

PATIENT NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____ TELEPHONE: _____

NAME OF RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____ NUMBER OF PERSONS LIVING IN HOUSEHOLD: _____

EMPLOYER: _____ ADDRESS:_____

IF UNEMPLOYED, HOW LONG?:_____

SPOUSE: _____

SPOUSE'S EMPLOYER: _____ ADDRESS: _____

IF UNEMPLOYED, HOW LONG?:_____

OTHER HOUSEHOLD MEMBER EMPLOYER(S): (INCLUDE MEMBER NAME, EMPLOYER, & ADDRESS:)

_____

_____

HOUSEHOLD INCOME & SOURCE

	PATIENT	SPOUSE	RESPONSIBLE PARTY (WHOM)	OTHER HOUSEHOLD MEMBERS
MONTHLY SALARY (GROSS)				
PUBLIC ASSISTANCE BENEFITS				
UNEMPLOYMENT BENEFITS				
SOCIAL SECURITY BENEFITS				
WORKMAN'S COMPENSATION				
CHILD SUPPORT				
OTHER (ALIMONY, ETC.)				

TOTAL HOUSEHOLD INCOME $_____

ANY ONE OF THE FOLLOWING DOCUMENTS MAY BE REQUIRED TO BASE THE FINAL DETERMINATION OF PAYMENT AMOUNTS OR ANY ADJUSTMENT:

I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE **Wyoming Cardiopulmonary Services, P.C**. TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.

_____

SIGNATURE OF PERSON MAKING REQUEST DATE

_____

SIGNATURE OF SPOUSE/OTHER DATE

DO NOT WRITE BELOW THIS LINE – FOR OFFICE PERSONNEL USE ONLY

This document was received on _____ by _____.
(date) (Name/Title)

REVIEW BY ADJUSTMENT BOARD ON: _____

RECOMMENDATIONS: