

## **Patient Application Procedures to Request Financial Assistance and/or Charity Care**

**This notice and applicable forms are provided to the patient upon request.**

### **Patient Eligibility Determination:**

Uninsured patients receiving services will be provided with the PCOM Financial Assistance Application (Schedule B) and the PCOM Insurance Attestation Form (Schedule A). The Patient may be required to submit some or all of the financial documentation listed below:

- Current health insurance card of Medical Assistance eligibility/denial notice from the State of Pennsylvania and/or County Services. Patients with neither will be provided to provide any necessary information to apply for available insurance or assistance.
- Proof of income and Adjusted Gross Income such as:
  - Income Tax returns for the most recently filed year or W-2 withholding statement
  - Pay stubs from the past six (6) pay periods or three months
  - Social Security checks, receipts or deposits
  - Bank statements - checking and savings
  - Other income
- Number of dependents in household
- Any other documentation that may serve as proof of Financial Assistance eligibility.

The financial resources of a parent or guardian may be considered in determining the eligibility of a patient who is dependent on the parent or guardian for financial support.

### **Patient Participation:**

Send a completed PCOM Financial Assistance and Charity Care Application to the **PCOM Billing Department at 4190 City Ave., Suite 428, Philadelphia, PA 19131** or email [FamilyMedicine@pcom.edu](mailto:FamilyMedicine@pcom.edu). When the Application for Financial Assistance and Charity Care is received, the billing staff will forward applications to the Chief Practice Operations Officer who will, either him/herself or through a designee, review and determine if the application is complete and whether the documentation supports the individual's eligibility for charity care or financial assistance based on the applicant's percentage of poverty (see addendum 2). Individuals will be notified of that determination within thirty (30) to sixty (60) days of receipt. Patients may contest the PCOM determination of eligibility by submitting additional documentation proving qualifications.

# **PCOM Insurance Attestation**

(To be completed and signed by patient)

Patient First and Last Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
*Number and Street City State ZIP Country*

SSN# (Last Four Digits): \_\_\_\_\_ Date of Service: \_\_\_\_\_

I hereby certify that (check a or b):

- a. I do not have insurance nor the ability to pay for the provided medical services, or  
 b. I have insurance but do not have the ability to pay the balance for the provided medical services.

If I do not have insurance I agree to provide any necessary information to apply for available insurance or assistance.

Initials: \_\_\_\_\_

I understand that by signing this document, I am applying for Financial Assistance for services provided by PCOM.

Initials: \_\_\_\_\_

If any information I have given proves to be untrue, I understand that PCOM may re-evaluate my financial status and I may become responsible for charges for services provided by PCOM.

Initials: \_\_\_\_\_

I certify the above information is true and complete. I understand that willful falsification of information contained in this application will result in denial of Financial Assistance.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

If you have questions, please contact the **PCOM Billing Department, 4190 City Ave., Suite 428, Philadelphia, PA 19131** or email **FamilyMedicine@pcom.edu**

### DISCLAIMER

PCOM reserves the right to request such information as pay stubs, income tax returns, bank statements, social security, and/or other liquid financial information deemed appropriate to determine qualification for assistance.

# **PCOM Financial Assistance Application**

(To be completed and signed by patient)

Patient First and Last Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
*Number and Street City State ZIP Country*

SSN# (Last Four Digits) \_\_\_\_\_ Date(s) of Healthcare Service \_\_\_\_\_

I hereby certify that I do not have the ability to pay for the medical services provided by PCOM on the date stated above.

I understand that by signing this document, I am applying for Financial Assistance. I will promptly provide the information necessary to process my application. Furthermore, I will apply for any assistance (Medicaid, Medicare, Insurance, etc.), that may be available to me for payment of my medical care charges. I will provide information and take action reasonably necessary to obtain such assistance and will assign or pay to PCOM, the amount recovered for the charges for medical services.

If any information I have given proves to be untrue, I understand that PCOM may re-evaluate my financial status and I may become liable for my medical service charges.

Last Date of Employment: \_\_\_\_\_

Employer: \_\_\_\_\_  
*Name Address*

Family Size (number of dependents in your household): \_\_\_\_\_

Annual Income: \_\_\_\_\_

Last 3 Months Income: \_\_\_\_\_

Please provide all documentation listed below that is relevant to you:

- o Current health insurance card of Medical Assistance eligibility/denial notice from the State of Pennsylvania and/or County Services. Patients with neither will be provided to provide any necessary information to apply for available insurance or assistance.
- o Proof of income and Adjusted Gross Income such as:
  - Income Tax returns for the most recently filed year or W-2 withholding statement
  - Pay stubs from the past six (6) pay periods or three (3) months
  - Social Security checks, receipts or deposits
  - Bank statements - checking and savings
  - Other income

*I certify that the above information is true and accurate to the best of my knowledge*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*Please Mail Completed Application To*  
PCOM Billing Department  
4190 City Ave, Suite 428  
Philadelphia, PA 19131  
or email [FamilyMedicine@pcom.edu](mailto:FamilyMedicine@pcom.edu)

## Patient Application Procedures to Request Financial Assistance and/or Charity Care

**PCOM maintains a uniform process for determining eligibility for financial assistance and charity care.**

Patients will be eligible for discounts, based on sliding fee class determined by percent of Poverty. Individuals and families with annual incomes at or under the Federal Poverty Guideline (FPG) will receive a 100% discount on all services and procedures. Individuals and families with annual incomes at or under 200% of the FPG will receive a 50% discount on all charges. No discount to individuals and families with annual incomes greater than twice those set forth in the FPG.

Annual incomes used against the FPG are determined by adding the total household income and the total family size. Family size is defines as the number of people who live in the home who are supported by the applicant's income, including him/herself.

As an example, if a household has two individuals earning \$12,000/yr and \$11,000/yr, and there are 3 other individuals in the household, they would be considered a household of 5 earning \$23,000/yr. According to the FPG below they would be under the FPG for their household size and therefor qualify for a 100% discount for PCOM medical services. If the combined income were \$45,000/yr (or any amount under twice the FPG for their household) this family would receive a 50% discount. If their combined annual income were great than \$64,940 they would not receive a discount.

<b>2022 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA</b>	
<b>Persons in family/household</b>	<b>Poverty guideline</b>
1	\$13,590
2	\$18,310
3	\$23,030
4	\$27,750
5	\$32,470
6	\$37,190
7	\$41,910
8	\$46,630
For families/households with more than 8 persons, add \$4,720 for each additional person.	