Financial Need. If a patient inquires about the Center's ability to discount or waive his or her financial responsibility, the Center may provide this only on the basis of financial need. The Center may waive or discount a patient's financial obligation as and to the extent set forth below if it determines that the patient has a demonstrated need for such financial accommodation. In such a case, the patient shall attest to his or her financial need, assets and sources of income by completing and signing the Financial Need Attestation in the form attached hereto as Exhibit A.

a. If the patient has a gross household income during the previous calendar year was, or expects to have a gross household income during the year in which services are provided, of less than 200% of the federal poverty level, adjusted for household size ("FPL"), then the Center may waive such patient's financial responsibility entirely.

b. If the patient has a gross household income during the previous calendar year was, or expects to have a gross household income during the year in which services are provided, of at least 300% of the FPL but less than of the FPL, then the Center may discount such patient's financial responsibility by **[50%]**.

c. If the patient has a gross household income during the previous calendar year was, or expects to have a gross household income during the year in which services are provided, of at least 400% of the FPL but less than of the FPL, then the Center may discount such patient's financial responsibility by **[25%]**.

d. In addition to household income, the Center may take into account in determining a patient's financial need any extenuating financial circumstances that may affect the patient's need for partial or full relief from his or her financial obligations. Examples of factors that the Center may consider include, but are not limited to the following:

    1. The patient's net worth, taking into account all liquid and non-liquid assets owned less any liabilities or claims against such assets;

    2. The patient's current employment status and future earnings potential;

    3. Patient's family size;

4. Other financial obligations of the patient, including living expenses and other items of a reasonable and necessary nature;

5. The amount and frequency of other healthcare/medication related bills relative to the factors listed above; and

6. Amounts received from all other sources of payment, including, but not limited to, third party payors, victims of crime programs and Medicaid.

Charity Care. The facility may from time to time be asked to provide care at no cost to those patients who have no insurance and cannot afford to pay for the cost of the care.

In such a case, the patient shall attest to his or her financial need, assets and sources of income by completing and signing the Financial Need Attestation in the form attached hereto as Exhibit A.

If the patient has a gross household income during the previous calendar year was, or expects to have a gross household income during the year in which services are provided, of less than 200% of the federal poverty level, adjusted for household size ("FPL"), then the Center may provide the care at no cost.

EXHIBIT A

Financial Need Attestation

Patient/Responsible Party Information

Guarantor/Responsible Party Name (full legal name)	
Patient Name (if other than responsible party)	Phone Number (Home)
Address (city, state, zip code)	Phone Number (Work)

Employer Information

☐ Guarantor/Responsible Party ☐ Patient ☐ Spouse Employer: Name	☐ Guarantor/Responsible Party ☐ Patient ☐ Spouse Employer: Name
Address	Address
Phone #	Phone #
Job Title	Job Title
Length of Employment	Length of Employment

Members of Household

Name	**Date of Birth**	**Relationship to you**

*Members of Household are defined as follows:

- If the patient is an adult include the patient, the patient's spouse and any dependents.
- If the patient is a minor, include the patient, the patient's father, dependents of the father, the patient's mother, and dependents of the mother.
- "Dependents" is defined in accordance with IRS guidelines.

***Income**

Source of Income	**Household Member**	**Amount Received**	**W-Weekly B-Biweekly M-Monthly A-Annually**

*Income represents cash receipts before taxes and includes but is not limited to, wages, salaries, tips; interest; dividends; taxable refunds, credits or offsets of state and local income taxes; alimony received; business income/loss; capital gains/loss; IRA distributions, pensions, and annuities; income from rental real estate, royalties, partnerships, S corporations, and trusts; farm income/loss, unemployment compensation; social security benefits, VA benefits, workman's compensation, and disability benefits.

If your income/lifestyle has changed, please explain and provide documentation (i.e. loss of job, death in the family, divorce, extraordinary medical bills or other expenses, etc.)

Please explain why you are requesting financial assistance. If applicable, please provide detailed information regarding any other circumstances that you would like the Center to consider in determining your eligibility for financial assistance.

In order to process your application this Financial Need Attestation should be signed and dated by the patient or other individual responsible for the patient and for payment for services rendered by the Center on the patient's behalf.

I hereby certify that the information provided is true and accurate to the best of my knowledge.

_____

Signature of Patient
(or Guarantor/Responsible Party if other than patient)

_____

Patient Name

_____

Guarantor/Responsible Party Name (if other than patient)

_____

Date