Effective Date: February 09, 2024 **Reviewed Date: February 09, 2024**
Approved: Tina Nichols/Don Duval

Harrison County Hospital has a tradition of serving the poor, the needy, and all who require health care services. In order to promote the health and well-being of the community served, individuals with limited financial resources shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon Federal Poverty guidelines. The need for financial assistance is based on income and may be re-evaluated at the following times:

- **Subsequent rendering of services,**
- **Income change,**
- **Family size change,**
- **When an account that is closed is to be reopened, or**
- **When the last financial evaluation was completed more than six months before.**

Appropriate signage will be visible in the facility, specifically in patient intake areas, creating awareness for the financial assistance program and the assistance available. Information, such as brochures, will be included in patient services/information folders and/or in patient intake areas. The Financial Assistance Policy and Application is available on our website, www.hchin.org, under Important Information. Paper copies of the Financial Assistance Application are visually placed in the main registration areas, are handed out to all uninsured patients during registration, and publicly advertised one time a year on the hospital's Facebook page. In addition, each statement includes a contact phone number to request a copy of the Financial Assistance Application and/or Policy. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area.

The necessity for medical treatment for any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

SPECIAL INSTRUCTIONS / GUIDELINES / FORMS TO BE USED

Cover Letter for Application, Application, Authorization to Release Information	**(Attachment # 1)**
My Income was Below the Federal and State Filing Requirements Form	**(Attachment # 2)**
Request for Verification of Bank Accounts	**(Attachment # 3)**
Financial Assistance Worksheet For Hospital	**(Attachment # 4)**
Catastrophic Financial Assistance Worksheet – Hospital Only	**(Attachment # 5)**
Final Request for Documentation Letter	**(Attachment # 6)**
Denial Letter	**(Attachment # 7)**
Confirmation of Social Security Exemption	**(Attachment # 8)**
Final Determination of Eligibility Letter	**(Attachment # 9)**
Payment Plan Letter	**(Attachment # 10)**

I. DEFINITIONS

A. Available Financial Resources: Include assets that are immediately available, cash and investments such as savings, checking as well as other investments.

B. Financial Assistance Committee: A committee consisting of the Chief Financial Officer, Patient Accounts Manager, Business Office Coordinator, Financial Counselor and Patient Advocate, Designated Medicaid Eligibility Representative(s).

C. Household: The patient, his/her spouse and his/her legal dependents according to the Internal Revenue Service rules. We reserve the right to require documentation but do not include income or assets of dependents age 18 or younger.

D. Presumptive Eligibility: When a patient is presumed to be eligible for financial assistance without being required to submit an application for financial assistance, based on factors such as being homeless, being eligible for federal, state or local assistance programs, (food stamps, federally subsidized school lunch program, low income or subsidized housing), or receiving free care from a community clinic.

II. FINANCIAL ASSISTANCE GUIDELINES

A. To be eligible for full financial assistance the household income must be at or below 200 percent of the current Federal Poverty Guidelines or be deemed to be presumptively eligible based on established criteria.

B. To be eligible for partial financial assistance (75 percent reduction of the patient portion of billed charges) a financially indigent patient's household income must be at or below 300 percent but more than 200 percent the Federal Poverty Guidelines.

C. Following the determination of eligibility for financial assistance you will not be charged more than the hospital's Amount Generally Billed (AGB) using the look back method. The hospital's AGB discount percentage is 66% and explanation of how it is calculated is available from the Finance department on request.

D. To be eligible for full or partial financial assistance an indigent patient must be a U. S. Citizen or in the country legally, and residing within either Harrison or Crawford County, Indiana or Meade County, Kentucky, or have an established relationship with a physician who is a member of the Harrison County Hospital medical staff. Patients' visits to Harrison County Hospital due to a medical emergency are eligible to apply for full or partial financial assistance, regardless of person's race, color, religion, sex, national origin, age, disability or genetic information.

E. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

F. To be considered for financial assistance, the patient must cooperate with the designated hospital representatives to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as, Medicare, Medicaid, HIP, COBRA, QMB, etc. To be eligible for assistance, the patient must apply for available government coverage such as Medicare Part B. If the patient is denied financial assistance related to failure to cooperate with Harrison County Hospital or government/state guidelines, they must wait 90 days from date of denial letter to reapply and previous accounts will not be eligible. Accounts originally classified as bad debts may be subsequently eligible for financial assistance for up to three years if not in legal collection status. If the patient is approved for assistance, a refund for the patient amount paid may be requested up to 180 days from the date the payment was posted, less collection fees.

G. Financial Assistance approval will be effective for six months or until a change in patient financial status is determined or is revoked due to non-cooperation. Hospital reserves the right to request additional information from patient during this six-month period. It is the patient's responsibility to notify hospital staff of accounts with balances that may be eligible for assistance.

H. Harrison County Hospital recognizes the fact that there may be instances in which a patient's income exceeds the previously mentioned guidelines, but the patient's medical expenses also exceed his or her income, thereby rendering them incapable of accepting any additional financial burdens. Financial assistance may also be appropriate for these individuals.

I. This policy will also apply to services provided by all hospital employed physicians, if the place of service is Harrison County Hospital.

III. IDENTIFICATION OF POTENTIALLY ELIGIBLE PATIENTS

A. Identification of potentially eligible patients can take place at any time during the rendering of services or during the collection process for up to 24 months following the date of service. Patients who are assigned to a hospital contracted collection agency may also be screened by that agency for financial assistance, with qualified recipients being reported to the hospital at least every 30 days. If the account is in collections at time of approval, agency fees may be deducted from any refund due patient.

B. Those patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program, such as Medicaid, prior to consideration for financial assistance.

C. Patients applying for financial assistance where it is reasonably believed they would qualify for a government financial assistance program (such as Medicaid or HIP) but do not apply due to religious beliefs, will be financially responsible for 15% of total charges on outpatient encounters and DRG Medicaid reimbursement rate on inpatient encounters. The patient should complete a written Application for Financial Assistance and submit Attachment # 8 (Confirmation of Social Security Exemption).

IV. DETERMINATION OF ELIGIBILITY

A. All patients identified as potential financial assistance recipients should be offered the opportunity to apply for financial assistance. Information on the availability of financial assistance is also included on every statement/bill sent to a self-pay patient.

B. The person requesting financial assistance should complete a written Application. For Financial Assistance (Attachment # 1) a completed application and supporting data should be returned to the Financial Counselor for evaluation. If the patient is food stamp, TANF or Medicaid eligible and can provide proof of eligibility then the need for other supporting data will be waived.

C. In the evaluation of an application for financial assistance, a patient's total household income and available financial resources will be taken into account. The amount of financial assistance to be provided will be reduced by any available resources in excess of $6,000 for an individual and increased by $2,000 for each individual household member.

D. Presumptive Eligibility: At Harrison County Hospital's discretion, Financial Assistance may also be considered and granted without completion of a Financial Assistance Application. Harrison County Hospital may refer to or rely on the following external factors and/or other program enrollment resources to determine patient's eligibility:

- **Patient is homeless**
- **Patient is eligible for other funded federal state or local assistance programs**
- **Patient is eligible for state or local assistance programs**
- **Patient is eligible for food stamps or federally subsidized school lunch program**
- **Patient is eligible for a state-funded prescription medication program**
- **Patient's valid address is considered low-income subsidized housing**
- **Patient receives free care from a community clinic and is referred to hospital for further treatment**
- **The patient expires and there is insufficient money in the estate or no estate to pay the patient's HCH bill.**
- **Patients who are deemed presumptively eligible for Financial Assistance may receive an adjustment to their account and may only be eligible on a specific date of service**

E. **Harrison County Hospital will not look to force liquidation of a personal residence, but may file a lien to protect our interest through future sale of such property. A credit report may also be generated.**

F. **Financial assistance approvals for amounts greater than $10,000 should be approved by the Patient Accounts Manager. Those greater than $25,000 should be approved by the CFO. The Financial Counselor shall notify the patient of the outcome.**

G. **Accounts where patients are identified as medically indigent or accounts where the collector or Patient Accounts Manager has identified special circumstances that when taken into consideration may affect the patient's eligibility for financial assistance will be referred to the Financial Assistance Committee for consideration and final determination.**

V. NOTIFICATION OF ELIGIBILITY DETERMINATION

A. **Clear guidelines as to the length of time required to review the application and provide a decision to the patient should be provided at the time of application. If additional documents are requested the patient is required to communicate and/or comply within 10 days. A prompt turnaround and a written decision to the patient, which provides a reason for denial, will be provided, generally within ten (10) days of the application process (once all documents are turned in) utilizing the Final Determination of Eligibility Letter (Attachment # 9). Applicants denied financial assistance may qualify for an extended interest free payment plan approved by the Patient Accounts Manager, not to exceed 18 months.**

VI. POLICY COMPLIANCE BY SERVICE LINE

A. **Collection activity may be suspended during the consideration of a financial assistance application. If a financial assistance determination allows for a percent reduction but leaves the patient with a self-pay balance, payment terms will be set up based on billing and collection policy. Actions to be taken by the hospital in the event of nonpayment are described in the billing and collections policy.**

B. **A free copy of the Billing and Collection Policy can be obtained by calling 812-738-8755.**

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA *FOR HOSPITAL*

Based upon Federal Poverty Guidelines, Gross income levels, 2024 (AGB discount 66% June 2024)

Family Size	100%	75%
1	0-30,120	30,121-45,180
2	0-40,880	40,881-61,320
3	0-51,640	51,641-77,460
4	0-62,400	62,401-93,600
5	0-73,160	73,161-109,740
6	0-83,920	83,921-125,880
7	0-94,680	94,681-142,020
8	0-105,440	105,441-158,160
Each Additional	10,760	16,140

List of Providers **Covered** by Financial Assistance Policy
In Harrison County Hospital Services Only

Anesthetists
Hospitalists
Orthopedic Surgeon
Podiatrist
Pediatricians

PROVIDER BASED OFFICES
Institutional Claims Only
Corydon Medical Associates
Dermatology & Skin Cancer Center
First Capital Medical Group
General Surgery Associates
Harrison Crawford Healthcare
HCH Pain Management
HCH OB/GYN
Kids First Pediatrics
Orthopedic Surgeons of Harrison County
South Harrison Family Medicine

List of Providers **Not Covered** by Financial Assistance Policy
Services of physicians, groups of physicians or other
practitioners that are not employed by the hospital,
including but not limited to
SCP Health – Emergency Room Physicians
Radiology Associates – Radiology Group
Women's Healthcare of Southern Indiana – Dr. Dunn, OB/GYN
Norton Specialty Groups – Oncology, Cardiovascular,
Gastroenterology, Vascular

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

FINANCIAL DOCUMENTATION REQUIRED FOR ALL MEMBERS OF THE HOUSEHOLD

Date:_____

Dear Patient,

In an effort to assist you with your medical expenses at Harrison County Hospital, an application for financial assistance is enclosed. Please **complete the application** and **provide copies** of the documentation checked below.

You may be contacted by a representative from an outside agency (ClaimAid or Complete Billing Services) who work with the hospital, to see if you are eligible for other payment sources that may be available. Failure to cooperate with one of these outside agencies will result in a denial of financial assistance.

For the application to be considered, you MUST return the following documents:
(Your application cannot be processed for consideration if the requested documentation is not included.)

__X__ Food Stamps or TANF ****If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.****

__X__ Federal Tax Return (1040) for the most recent year (or IRS Form 4506-T).

__X__ Last Three Months of Financial Information:
(Checking, Savings and Investments - ***please include all pages of each statement*****)**

__X__ Pay Stubs for the last 13 weeks for patient and spouse (or last 7 bi-weekly pay stubs), if income has changed since previous year's tax return.

__X__ Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc.).

__X__ Other: If either you or your spouse have no income then that person must submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.

Other: _____

_____

Please return materials **by mail or fax (812) 738-8780** within 10 days or call me **to schedule an appointment to copy and review** the information. If you have any questions, please feel free to call me **at (812) 738-7846**.

Thank you,

Stephanie Lovings
Financial Counselor
1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

Harrison County Hospital

APPLICATION FOR FINANCIAL ASSISTANCE **ACCOUNT # _____**

I hereby request that Harrison County Hospital make a written determination of my eligibility for financial assistance services. I understand that the information, which I submit concerning my annual income and family size, is subject to verification by this Hospital. I also understand that if the information, which I submit, is determined to be false, such a determination will result in a denial of financial assistance and that I will be liable for charges for services provided.

PLEASE PRINT

1. GUARANTOR ***(person responsible for payment)***

Name: _____DOB:___/____/___ Social Security #: _____
Last First MI
Address:_____ Phone #(_____)_____
Number and Street City State Zip
County:_____ Primary Physician:_____

2. EMPLOYER _____ OCCUPATION_____

Address:_____ Phone #(_____)_____
Number and Street City State Zip

3. PATIENT'S information ***if different than Guarantor***

Name: _____DOB:___/____/___ Social Security #: _____
Last First MI
Address:_____ Phone #(_____)_____
Number and Street City State Zip

4. PATIENT'S Spouse

Name: _____DOB:___/____/___ Social Security #: _____
Last First MI
Address:_____ Phone #(_____)_____
Number and Street City State Zip

SPOUSE'S EMPLOYER _____ OCCUPATION_____

5. Has guarantor filed bankruptcy in the last 12 months? Yes No

6. FAMILY SIZE _____ (*All persons claimed on tax return*)

7. INCOME: List income for all the family members claimed on your tax return. ***Attach proof of the supporting income***

NAME RELATIONSHIP AGE	NAME RELATIONSHIP AGE
1.	5.
2.	6.
3.	7.
4.	8.

APPLICATION FOR FINANCIAL ASSISTANCE *continued*

8. TOTAL AMT. FOR LAST 13 WEEKS

Gross Wage	**$_____**
Self-Employment or Personal	**$_____**
TANF Benefits	**$_____**
Food Stamps Benefits	**$_____**
Social Security/Disability	**$_____**
Unemployment Compensation	**$_____**
Worker's Compensation	**$_____**
Child Support	**$_____**
Pensions	**$_____**
Income from Dividends, Interest, or Rental	**$_____**
Other (Please Explain)	**$_____**

TOTALS $_____

9. ASSETS (please provide copies **for last 3 months**)

$_____Checking Acct Balance

Financial Institution Name: _____

$_____ Saving Acct Balance

Institution Name: _____

$_____Investments (Stocks, Bonds, Mutual Funds, Money Market Account(s), CD's)

$_____Other Assets (please describe)

_____

$_____ TOTAL ASSETS

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA *FOR HOSPITAL*

Based upon Federal Poverty Guidelines, Gross income levels, 2024

Family Size	100%	75%
1	0-30,120	30,121-45,180
2	0-40,880	40,881-61,320
3	0-51,640	51,641-77,460
4	0-62,400	62,401-93,600
5	0-73,160	73,161-109,740
6	0-83,920	83,921-125,880
7	0-94,680	94,681-142,020
8	0-105,440	105,441-158,160
Each Additional	10,760	16,140

If you would like a copy of the Financial Assistance Policy go to WWW.HCHIN.ORG or call (812) 738-7846.

AUTHORIZATION TO RELEASE INFORMATION

The undersigned certifies the following:

1. **Patient and/or guardian has applied for financial assistance with Harrison County Hospital and as part of the application process, it is understood that Harrison County Hospital may verify information contained in patient and/ or responsible party's application and in other documents such as the patient's credit report which may have been supplied in connection with the financial assistance application.**

2. **Patient and/or responsible party duly authorize you to release and provide to Harrison County Hospital any and all information and documentation that they may request. I give permission to Harrison County Hospital to discuss any accounts that are in the patient and/or guardian's name.**

3. **A photo or faxed copy of this authorization may be accepted as an original.**

_____	_____
Printed Patient's or Responsible Party Name	**Patient's or Responsible Party Signature**
_____	_____
Social Security Number	**Date**
_____	_____
Printed Spouse/Other's Name	**Spouse/Other's Signature**
_____	_____
Social Security Number	**Date**

I understand that the information which I submit is subject to verification by Hospital. I certify that the above information is true, correct, and complete.

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

Date:_____

My income was below the federal and state filing requirements, therefore; I did not file a tax return in the year _____.

_____ _____
Patient's Signature **Date**

_____ _____
Spouse's Signature **Date**

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

Request for Verification of Bank Accounts

Institution:_____Date: _____

Customer:_____ SSN #:_____

I give my permission to the above institution to provide Harrison County Hospital the information requested below via mail or fax. This permission expires one year after the date I sign this form.

Signature	Date

This information is required to determine eligibility for a medical assistance program of eligibility and released only to the governing agency that makes the determination. The information given will be kept confidential. Please return this completed form **within 10 days to:**

Harrison County Hospital
Attn: Stephanie Lovings
1141 Hospital Dr. NW **FAX 812-738-8780**
Corydon, IN 47112
812-738-7846

Please complete all requested information below OR provide statements covering these dates

Acct Type (Ch, Sa, CD, Other)	Last 2 Acct #	Balance Date _____	Balance Date _____	Amount, Date & Frequency of Last Interest Payment (monthly, etc.)	Other Names on Acct.

Closure of Accounts? ☐ YES ☐ NO Date and Balance at Closure: _____

Account Number: _____

Typed Name or Stamp of financial institution	Signature and Tile of Officer	Date Signed

Harrison County Hospital
FINANCIAL ASSISTANCE WORKSHEET *FOR HOSPITAL*
(FOR FINANCE OFFICE USE ONLY) **Application Date _____**

Name of Applicant _____Phone #_____

Account #(s) _____

Balance $ _____

Annual Household Income $ _____

Total Available Financial Resources $_____

Credit Report Available Yes No

Percentage Financial Assistance per Guidelines_____

Amount Approved $_____

Date of Determination_____

Approved By _____ Date_____

Denied By _____ Date_____

Referred To:

Patient Accts Mgr _____ CFO _____ Financial Assistance Committee _____

FINANCIAL ASSISTANCE ELIGIBILITY CRITERIA *FOR HOSPITAL*

Based upon Federal Poverty Guidelines, Gross income levels, 2024

Family Size	100%	75%
1	0-30,120	30,121-45,180
2	0-40,880	40,881-61,320
3	0-51,640	51,641-77,460
4	0-62,400	62,401-93,600
5	0-73,160	73,161-109,740
6	0-83,920	83,921-125,880
7	0-94,680	94,681-142,020
8	0-105,440	105,441-158,160
Each Additional	10,760	16,140

Harrison County Hospital

CATASTROPHIC FINANCIAL ASSISTANCE WORKSHEET – HOSPITAL ONLY

(FOR FINANCE OFFICE USE ONLY)

NAME OF APPLICANT _____ **APPLICANT PHONE #** _____

ACCOUNT #(S) _____ **BALANCE $** _____

TOTAL AMOUNT REQUESTED $_____ **CREDIT REPORT AVAILABLE YES NO**

DATE REQUESTED _____ **DATE REFERRED TO FINANCIAL ASSISTANCE COMMITTEE**_____

GROSS VALUE OF HOME AND OTHER REAL ESTATE $_____
LESS RELATED DEBT $_____
NET VALUE OF HOME AND OTHER REAL ESTATE $_____
ANY OTHER EXTENUATING CIRCUMSTANCES: _____

CATASTROPHIC FINANCIAL ASSISTANCE CALCULATION PROCESS	**12 Month Period**
Time Period Covered	_____ - _____ mm/dd/yy mm/dd/yy
Total Household Income	**A.**_____
Income Factor	**B. x 25%**
Income Threshold	**C.**_____ **(A x B)**
Total HCH Hospital Bills (After all 3rd Party Payments, excluding financial assistance adjustment)	**D.**_____ **(12 mo.)**
Total Other Medical Bills (After all 3rd Party Payments, if any)	**E.**_____ **(12 mo.)**
Total Medical Bills	**F.**_____ **(D + E)**
Medical Bills in Excess of Income Threshold (If number is negative, does not qualify)	**G.**_____ **(F - C)**
Catastrophic Financial Assistance Allocation Factor	**H.**_____ **(D ÷ F)**
Maximum Allowable Catastrophic Financial Assistance **If greater than zero, then greater of amount on I or 65%**	**I.**_____ **(H x G)**

DETERMINATION

AMOUNT APPROVED $_____ **DATE OF DETERMINATION**_____

APPROVED BY _____ **DATE**_____

DENIED BY _____ **DATE**_____

REASON DENIED _____

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

FINAL REQUEST FOR DOCUMENTATION

Final Request for Documentation

Date:_____

_____

_____

_____

Dear _____,

Your application for financial assistance was received. The following required documentation was not included. Please return your documentation within 10 days or your application will be denied and you must wait at least 90 days before re-applying

_____ Food Stamps or TANF: ***If you provide proof of current eligibility for Food Stamps or TANF you do not need to provide any other documentation other than the proof of eligibility letter and filled out application form.****

_____ Federal Tax Return (1040) for the most recent year (or IRS Form 4506-T)

_____ Last Three Months of Financial Information (Checking, Savings and CD's)

_____ Pay Stubs for the last 13 weeks (or last 7 bi-weekly pay stubs), if income has changed since previous year's tax return.

_____ Proof of Any Other Income (i.e. Social Security, Child Support, Rental Income, Unemployment, Pension, Self-Employment, etc...)

_____ Other: If you have no income submit a signed personal statement noting the date you last worked and/or the start date of disability and how primary household expenses are paid.

Other: _____

If you have any questions, please feel free to call me **at (812) 738-7846**.

Thank you,

Stephanie Lovings
Financial Counselor

1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

Date:_____

_____

_____

_____

Dear _____,

We have reviewed your request for Financial Assistance with Harrison County Hospital. Your request is denied due to the amount of your income and/or available financial resources.

Thank you for considering Harrison County Hospital. If you have any questions or concerns please do not hesitate to call.

Thank you,

Stephanie Lovings
Financial Counselor

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

Date:_____

_____

_____

_____

Dear _____,

In an effort to assist you with your medical expenses at Harrison County Hospital, please respond to the information below.

I am unable to apply for Medicaid or have no social security number for the following reason:

☐ **Due to religious beliefs**
If so, please explain:

Please provide a letter from a local leader of your religious order for confirmation.
_____

☐ **Not a U.S. citizen**

_____ _____
Patient Signature **Date**

Thank you,

Stephanie Lovings
Financial Counselor

1141 Hospital Drive NW • Corydon, IN 47112 • (812) 738-7846 • (800) 447-4251 ext. 2230 • Fax: (812) 738-8780

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

FINAL DETERMINATION
OF ELIGIBILITY

Application Date: _____

_____

_____

_____

Dear _____,

Your request for financial assistance has been reviewed and the determination is as follows:

_____ **Your request for uncompensated care has been denied because your income exceeds the income criteria specified under the Federal Poverty Guidelines.**

_____ **Partial Approval - you owe only** $_____**on your account(s).**

_____ **100 % Approval - You owe nothing on your account (s).**

_____ **Other: _____**

Unfavorable decision may be appealed in writing to my attention at the address below within 20 days after the date of this letter. Catastrophic medical expenses can be introduced during this appeal.

Patients are responsible for contacting any other agencies regarding their billing and policies. Harrison County Hospital only reviews and makes determination for charity for Harrison County Hospital patients' accounts.

This eligibility determination covers the following services only. If you have any other hospital account not listed below please contact me.

Account #	Date of Service	Amount Approved	Balance Due		Account #	Date of Service	Amount Approved	Balance Due

TOTAL CHARGES: **$_____**

TOTAL FINANCIAL ASSISTANCE APPROVED: **$_____**

TOTAL ACCOUNT (S) BALANCE DUE: **$_____**

If you are unable to pay the discounted amount in full, please call (812) 738-7846 immediately to set up payment arrangements. Thank you.

Sincerely,
Stephanie Lovings
Financial Counselor

Signed: _____Date:_____

HARRISON COUNTY HOSPITAL
An affiliate of NORTON HEALTHCARE

Date:_____

_____

_____

_____

Dear _____,

Thank you for choosing Harrison County Hospital for your Healthcare Needs.

We understand that with the financial challenges that many are facing with today's economy you may not be able to pay for your procedure in full at the time of service.

Account # _____

You agree to pay a deposit amount of $ _____.

You agree to make a monthly payment of $_____ due on the _____ of each month until the balance is paid in full.

The estimated balance for your procedure is _____. This estimate is based on the average cost of this procedure without any unforeseen complications. In the event there are complications, you will be notified and billed.

Your next payment is due on _____.

Please sign below to signify that you agree to pay this account as stated above.

X_____ _____
Patient or Guardian Signature **Date**

If you have any questions, please feel free to contact me at 812-738-7846.
Thank you,

Stephanie Lovings
Financial Counselor
Harrison County Hospital