Meridian Valley Health System

Patient Financial Services · P.O. Box 55120, Fairhaven, ST 58027-5120
Billing 1-855-555-0130 (Mon–Fri 8:00 a.m.–6:00 p.m.) · Fax 1-855-555-0139
mvhs.example/billing · Language assistance and TTY 711 available at no cost

FINANCIAL ASSISTANCE APPLICATION

Policy
FAP-2027-01
Effective
January 1, 2027
Application form
MVH-FAP-014
Assistance line
1-855-555-0134

Financial Assistance Program Application

Eligibility screening, household and income definitions, required documents, and the application form itself

APPLYING IS FREE, AND ASKING NEVER MAKES YOUR BALANCE WORSE

Your account is held from collection activity for 45 days while an application is pending, and no account is referred to an outside agency while a complete application is under review.

APPLICATION WINDOW	DECISION TIMELINE	APPROVAL PERIOD	LOOK-BACK
240 days after the first post-discharge statement	**30 days from a complete application**	**12 months, then recertify**	**Applies to accounts within 240 days, including amounts already paid**

STEP 1 — SCREEN YOURSELF BEFORE YOU GATHER ANYTHING

1. Add up the gross annual income of everyone in your household as defined in step 2.
2. Find your household size in the program income standard table below and read across to the 200% and 400% columns.
3. Divide your household income by the standard for your household size and multiply by 100. That percentage determines your discount tier.
4. If the percentage is at or below 500%, you are within the program range and should apply.
5. If the percentage is above 500%, apply anyway if you have catastrophic medical debt — the catastrophic provision in step 6 is evaluated separately from income.

PROGRAM INCOME STANDARD — ANNUAL, BY HOUSEHOLD SIZE

HOUSEHOLD SIZE	STANDARD	200% OF STANDARD	400% OF STANDARD
1	$15,600	$31,200	$62,400
2	$21,100	$42,200	$84,400
3	$26,600	$53,200	$106,400
4	$32,100	$64,200	$128,400
5	$37,600	$75,200	$150,400
6	$43,100	$86,200	$172,400
Each additional person	add $5,500	add $11,000	add $22,000

These amounts are invented for this specimen. A real program publishes a standard tied to an official federal guideline that is updated annually.

DISCOUNT TIERS APPLIED TO THE PATIENT BALANCE

INCOME AS % OF STANDARD	DISCOUNT	YOU WOULD OWE
At or below 200%	100%	Nothing — full charity care
201% to 300%	80%	20% of the patient balance
301% to 400%	60%	40% of the patient balance
401% to 500%	40%	60% of the patient balance
Above 500%	Not eligible on income	Payment plan or catastrophic review

The discount applies to the patient balance after insurance has processed the claim — never to the gross charges, and never to amounts your plan is obligated to pay.

A WORKED EXAMPLE

STEP	CALCULATION	RESULT
1	Household size (two adults and two children under 18 living in the home)	4
2	Combined gross annual income from all sources for the household	$88,000.00
3	Program income standard for a household of four	$32,100.00
4	Income as a percentage of the standard: $88,000.00 ÷ $32,100.00 × 100	274.1%
5	Discount tier for 201%–300%	80% discount
6	Patient balance on the account after insurance processed the claim	$1,669.68
7	Discount amount: $1,669.68 × 80%	$1,335.74
8	Remaining patient responsibility: $1,669.68 – $1,335.74	$333.94
	AMOUNT OWED AFTER ASSISTANCE — ELIGIBLE FOR A PAYMENT PLAN	**$333.94**

The example uses the $1,669.68 patient responsibility from the itemized statement specimen for the April 18, 2027 encounter, before the $650.00 already paid. Amounts already paid within the 240-day look-back are refunded to the extent the approved discount exceeds them.

STEP 2 — WHO COUNTS AS YOUR HOUSEHOLD, AND WHAT COUNTS AS INCOME

INCLUDED IN THE HOUSEHOLD

- The patient and the patient's spouse or domestic partner living in the home
- All dependent children under 18 living in the home
- Dependent children 18 to 23 enrolled full time in school, whether or not living at home
- Any other person claimed as a dependent on the most recent tax return

COUNTED AS INCOME

- Wages, salary, tips, commissions, and bonuses before deductions
- Self-employment net income after business expenses
- Unemployment compensation and workers' compensation
- Social Security, retirement, pension, and annuity payments
- Alimony received, rental income, and regular investment income

NOT INCLUDED IN THE HOUSEHOLD

- Roommates, unrelated adults, and non-dependent adult children
- Relatives who live in the home but file independently and are not claimed as dependents

NOT COUNTED AS INCOME

- Supplemental nutrition or housing assistance benefits
- Foster care payments and adoption assistance
- One-time gifts, inheritances, and tax refunds
- The value of your primary residence, one vehicle per licensed driver, and retirement accounts
- Court-ordered child support paid out of the household

STEP 3 — DOCUMENTS TO ATTACH

SITUATION	ATTACH ANY ONE OF THESE
Employed	Two most recent consecutive pay stubs, or an employer letter on letterhead stating gross pay and frequency
Self-employed	Most recent federal tax return with Schedule C, or three months of business bank statements
Retired or on benefits	Current benefit award letter, or two months of statements showing the deposit
Unemployed	Unemployment determination letter, or a signed statement of no income using form MVH-FAP-014A
Any household	Most recent filed federal tax return, all pages, or an IRS non-filing letter

Send copies, never originals. Black out all but the last four digits of any Social Security number. We do not require a credit report and we never run one.

STEP 4 — HOW TO SUBMIT

METHOD	WHERE	CONFIRMATION
Online	mvhs.example/assistance	Immediate on-screen reference number
Mail	Financial Assistance, P.O. Box 55124, Fairhaven, ST 58027-5124	Letter within 10 business days
Fax	1-855-555-0139	Letter within 10 business days
In person	Any registration desk or the business office	Stamped copy at the counter
By phone	1-855-555-0134 for help completing the form	Reference number by phone

Keep your reference number. Every status question is answered faster with it.

STEP 5 — WHAT HAPPENS AFTER YOU SUBMIT

STAGE	WHAT WE DO	WHAT YOU DO	TIMING
Receipt	Log the application, assign a reference number, and place a 45-day hold on collection activity	Keep the reference number	Within 5 business days
Completeness check	Confirm every required document is attached and legible	Nothing yet	Within 10 business days
Request for information	Mail a written list of exactly what is missing	Send the missing items	You have 21 days to respond
Determination	Apply the income calculation and the discount tier	Nothing	30 days from a complete application
Decision letter	Mail a letter stating the tier, the discount, the accounts affected, the remaining balance, and appeal rights	Read it and calendar the recertification date	Within 5 business days of the determination
Account adjustment	Post the discount to every covered account and refund any overpayment	Confirm the next statement reflects it	Within 15 business days

If the application is denied, the letter states the reason and the specific figure relied on. You may ask for reconsideration within 30 days of the letter date, including new documents.

STEP 6 — PROVISIONS THAT APPLY WITHOUT A FULL INCOME APPLICATION

PROVISION	WHEN IT APPLIES	EFFECT
Presumptive eligibility	Enrollment in a qualifying public assistance program, or documented homelessness or deceased with no estate	100% discount applied without an income application
Catastrophic medical debt	Patient balances across all accounts in a 12-month period exceed 25% of household income, regardless of income level	Balance above the 25% threshold is discounted
Uninsured discount	No insurance coverage on the date of service	Charges reduced to the amount generally billed before any assistance is applied
Emergency care protection	Emergency and medically necessary care	No patient is charged more than the amount generally billed to insured patients

APPLICATION FORM MVH-FAP-014 — COMPLETE EVERY FIELD

PATIENT NAME (LAST, FIRST, MIDDLE)	DATE OF BIRTH	ACCOUNT NUMBER(S)	GUARANTOR NAME
MAILING ADDRESS	CITY / STATE / ZIP	DAYTIME PHONE	EMAIL
HOUSEHOLD SIZE	COMBINED GROSS ANNUAL INCOME	INCOME AS % OF STANDARD	INSURANCE STATUS ON THE DATE OF SERVICE **Insured / Uninsured / Coverage ended**

Household members — list everyone counted in step 2:

FULL NAME	RELATIONSHIP TO PATIENT	AGE	EMPLOYER OR INCOME SOURCE	GROSS ANNUAL INCOME
Total household gross annual income				

Certification: I certify that the information on this application is true and complete to the best of my knowledge. I understand that Meridian Valley Health System may verify this information, that I must report a significant change in household size or income within 30 days, and that an approval based on information later found to be materially false may be reversed.

SIGNATURE OF PATIENT OR GUARANTOR	PRINTED NAME	DATE	STAFF USE — REFERENCE NUMBER

Important: This form and the figures in it are a demonstration specimen. Approval, discount tiers, look-back periods, and appeal rights are governed by the written policy in effect on your date of service and by applicable law. Nothing here guarantees approval, a particular discount, or a refund, and nothing here is legal, tax, or financial advice.