Dear Patient:

All affiliated physician practices of Sentara Halifax Regional Hospital implemented a Patient Financial Assistance Policy. Qualification for financial assistance is determined by the Federal Poverty Guidelines. Should you wish to apply, please complete the attached Patient Financial Assistance Application (PFAA) and return within 30 days with required supporting financial documentation related to household income and dependents. The acceptable types of proof of income are indicated on the application. These **MUST** be included for consideration. If no income exists, the patient or responsible party is required to sign a statement of no income.

FEDERAL POVERTY INCOME GUIDELINES (FPG)					
Household Size	100%	150%	175%	200%	225%
1	$12,490	$18,735	$21,857	$24,980	$28,102
2	$16,910	$25,365	$29,592	$33,820	$38,047
3	$21,330	$31,995	$37,327	$42,660	$47,992
4	$25,750	$38,625	$45,062	$51,500	$57,937
5	$30,170	$45,255	$52,797	$60,340	$67,882
6	$34,590	$51,885	$60,532	$69,180	$77,827
7	$39,010	$58,515	$68,267	$78,020	$87,772
8	$43,430	$65,145	$76,002	$86,860	$97,717

Once your application has been processed, our office will notify you by letter of your determination. If a discount is approved, your account will be adjusted appropriately. The approved discount is effective for a period of 12 months from the date of the application. It is your responsibility to reapply when the application has expired.

You are expected to pay a $25 copay for Family Practices, Anesthesia & Pediatrics and a $50 copay for all Specialty Practices at the time of service. All Surgical procedures will require a 10% copayment plus an additional 5% copayment for each Physician Assist, for which you will be billed. You are responsible for any remaining balance once your application is processed and adjustments have been made to your account. SDHG reserves the right to designate certain services which are not subject to this charity care policy. Granting of charity care is contingent upon satisfactory payment arrangements on any remaining non-charity portion of the bill. Failure to honor payment arrangements on amounts exceeding the charity adjustment may result in the total charity care being revoked.

This discount applies to: **Sentara Behavioral Health Specialists**, **Sentara Chase City Family Medicine, Sentara Clarksville Family Medicine, Sentara Halifax Anesthesiology, Sentara Halifax Family Medicine, Sentara Halifax General Surgery, Sentara Obstetrics & Gynecology, Sentara Halifax Pediatrics, Sentara Southern Virginia Ear, Nose & Throat, Sentara Southern Virginia Orthopedics, Sentara Southside Hematology & Oncology and Sentara Volens Family Medicine.**

This policy establishes the framework pursuant to SDHG that will identify patients that may qualify for charity care; provide charity care; and account for charity care in accordance with the requirements set forth in the Virginia Code and consistent with generally accepted accounting practices. The determination of eligibility for reduced fee care only covers physician services. This does not cover charges billed separately by Sentara Halifax Regional Hospital or private physicians. ***Patients with active Medicare Part B coverage, Liability Insurance or Personal Injury Claims are not eligible to apply for SDHG Patient Financial Assistance.**

ACKNOWLEDGMENT: I understand that failure to pay my PFAA copayment at office visits or to make arrangements to pay any Surgical copayments in a timely and satisfactory manner will result in a reversal of charity benefits. Please sign and return this with your application for assistance.

Signature:_____ **Date:** _____

RESERVATION OF RIGHTS: **SDHG reserves the right to limit or deny financial assistance at its sole discretion.**

SENTARA DOMINION HEALTH GROUP
PATIENT FINANCIAL ASSISTANCE APPLICATION

Today's Date:_____ Account #:_____ Name of Practice:_____

Patient's Name:_____
First Middle Last

Guarantor's Name: _____
First Middle Last

Address:_____ Phone: _____

Number of Dependents:_____(including yourself, spouse, children under 21 years of age, unless FT student)

Name	Age	Relationship	Gross Monthly Income	Source of Income
1				
2				
3				
4				
5				
6				

Do You File Taxes? YES NO (If YES, please attach a copy of most recent Federal Income Tax Return).

Was this service due to an accident in which you may have a personal injury claim or have representation by an attorney? YES NO

If YES, please provide attorney's name and contact information._____

In order to be considered for eligibility, your **most recent tax return is required**. If taxes NOT filed, please provide two most recent check stubs, SSA benefit letters, or verification of any other source of income **FOR ALL HOUSEHOLD MEMBERS.**

Authorization

I authorize Sentara Dominion Health Group to verify all information contained in this financial statement with employers and/or other agencies, including credit reporting agencies. Everything on this financial statement is true and correct. I also understand that I am expected to apply for any State/Federal resources that I may qualify for.

Signature:_____ **Date:_____**

Return Completed Application with Supporting Documents to:
Sentara Dominion Health Group, Attn: Patient Financial Assistance, P.O. Box 860, South Boston, Virginia 24592.

DO NOT WRITE BELOW THIS LINE. FOR OFFICE USE ONLY.

Excess Income: _____ Total Annual Income: _____

Determination of Financial Assistance

Discount 100%_____ 75%_____ 50%_____ 25% _____

Office Staff_____ Date _____

Sentara Dominion Health Group
No Income Statement

I,_____, did not receive any income for

the months of_____.

Signature:_____Date: _____