Southcoast Behavioral Health	Department: Business Office Effective Date: 2015 Approved By: Northeast Behavioral Health, LLC Management Board
POLICY: Financial Assistance Policy	

I. Purpose:

Northeast Behavioral Health, LLC d/b/a Southcoast Behavioral Health (the "Company") owns and operates a 192-bed inpatient hospital in Dartmouth, Massachusetts providing behavioral health services to the public ("Hospital"). The Company seeks to operate the Hospital and provide behavioral health services to the public in a manner consistent with the charitable purposes and activities generally required of hospitals described in Section 501(c)(3) of the Internal Revenue Code. The purpose of this Financial Assistance Policy is to ensure that processes and procedures exist for identifying and assisting patients whose care may be provided without charge or at a discount commensurate with their financial resources and ability to pay.

II. Overview:

In furtherance of its charitable purposes, the Hospital will provide both (i) emergency treatment to any person requiring such care; and (ii) medically necessary behavioral health care services to patients who are permanent residents of the Commonwealth of Massachusetts (and others on a case-by-case basis) who meet the conditions and criteria set forth in this policy; in each case, without regard to the patients' ability to pay for such care.

It is the policy of the Hospital to provide financial assistance (care either for free or at discounted rates) to persons or families where: (i) there is limited or no health insurance available; (ii) the patient fails to qualify for governmental assistance (for example, Medicare or Medicaid); (iii) the patient cooperates with the Hospital in providing the requested information demonstrating financial need, or other facts and circumstances readily demonstrate financial need; and (iv) the Hospital makes an administrative determination that financial assistance is appropriate based on the patient's ability to pay (as established by family income or based on criteria demonstrating presumptive eligibility) and the size of the patient's medical bills.

After the Hospital determines that a patient is eligible for financial assistance, the Hospital will determine the amount of financial assistance available to the patient by utilizing the Financial Assistance Guidelines (set forth as **Exhibit 1**). The Guidelines reflect family income levels tied to the most recent Federal Poverty Guidelines, and establish corresponding discount percentages. The Guidelines are to be adjusted annually to reflect

the annual update to the Federal Poverty Guidelines, and to adjust the corresponding discount percentages to ensure that, in all cases, a patient determined to be eligible for financial assistance will not be billed more than the amounts generally billed by the Hospital for the same emergency or medically necessary behavioral health services to individuals who have insurance covering such care.

The Hospital will regularly review this Financial Assistance Policy to ensure that at all times it: (i) reflects the mission of the Company; (ii) explains the decision processes of who may be eligible for financial assistance and in what amounts; and (iii) complies with all applicable state and federal laws, rules, and regulations concerning the provision of financial assistance to patients who are uninsured or otherwise eligible.

III. Nondiscrimination:

A. The Hospital will render behavioral health services, inpatient and outpatient, to all Massachusetts residents who are in need of emergency or medically necessary behavioral health services, regardless of the ability of the patient to pay for such services and regardless of whether and to what extent such patients may qualify for financial assistance pursuant to this policy.

B. The Hospital will not engage in any actions that discourage individuals from seeking emergency care, such as by demanding that emergency patients pay before receiving treatment or by permitting debt collection activities in the Admissions Department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

IV. Definitions:

A. Assets: Any item of economic value owned by an individual, especially one that could be converted to cash. Examples are cash, securities, accounts receivable, inventory, equipment, a house (other than primary residence), a car, and other property. For these purposes, assets do not include a primary residence or other property exempt from judgment under Massachusetts law, or any amounts held in pension or retirement plans (although distributions and payments from such plans may be included as family income for purposes of this policy).

B. Bad Debt Expense: Uncollectible accounts receivable (where reasonable attempts to collect have been made), excluding contractual adjustments, arising from the failure to pay by patients: (i) whose health care has not been classified as financial assistance care; or (ii) who have qualified for financial assistance in the form of discounted care but have failed to pay the remaining balances due after application of discounts pursuant to this policy.

C. Family: The patient, his or her spouse (including a legal common-law spouse) and his or her legal dependents according to Internal Revenue Service rules.

D. Family Income: The sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. Family income includes gross wages, salaries, dividends, interest, Social Security benefits, workers' compensation, veterans' benefits, training stipends, military allotments, regular support from family members not living in the household (other than child support), government pensions, private pensions, insurance, annuity payments, income from rents, royalties, estates, trusts, and other forms of income.

E. Financial Assistance: Either full or partial reduction in charges to patients for emergency or medically necessary behavioral health services, in the case of patients who are financially eligible, presumptively eligible, or medically indigent, as those terms are defined in this policy. Financial assistance does not include bad debt or contractual shortfalls from government programs, but may include insurance co-payments, deductibles, or both.

F. Financially Eligible: A patient whose family income is at or below 350% of the Federal Poverty Guidelines, as set forth in **Exhibit 1** hereto, as demonstrated based on factual information provided by the patient on the Financial Assistance Application.

G. Medically Indigent: A patient whose medical or hospital bills after payment by a third-party payer exceed 25% of the patient's annual family income, and who is financially unable to pay the remaining bill. A patient who incurs catastrophic medical expenses is classified as medically indigent when payment would require liquidation of assets critical to living or would cause undue financial hardship to the family support system.

H. Medically Necessary: Any inpatient or outpatient behavioral health service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Medicare. Medically necessary services do not include non-medical services such as social and vocational services, or other services deemed "elective."

I. Presumptively Eligible: A patient who has not submitted a completed Financial Assistance Application, but who meets one of the following may be considered presumptively eligible:

- Medicaid eligible, but not on the date of service or for non-covered services;
- Enrolled in one or more governmental programs for low-income individuals having eligibility criteria at or below 200% of the Federal Poverty Guidelines; or
- After authorizing (via the form attached as **Exhibit 2**) the Hospital to calculate his or her income-to-debt ratio using Decision Power, an Equifax product, or similar service, is shown to be at or below 200% of the Federal Poverty Guidelines.

The Hospital's trained *Financial Counselors* will routinely review the foregoing criteria with patients, before asking patients to complete the Financial Assistance Application. The Hospital may also utilize other software programs or automated systems to determine presumptive eligibility. Patients who meet any of the foregoing

criteria for presumptive eligibility will be deemed to be eligible for a 100% discount, and will not be asked or required to submit a Financial Assistance Application. The Decision Power calculation or other program or system will not be used to determine or presume ineligibility.

V. Eligibility for Financial Assistance:

A. Financial assistance will be given for emergency or medically necessary behavioral health services to patients who are financially eligible or medically indigent (in both cases, based on information provided via the Financial Assistance Application attached as **Exhibit 3**), or to patients who have been determined to be presumptively eligible. In addition, financial assistance may be provided in other circumstances on a case-by-case basis as determined by the Hospital's *Chief Financial Officer* (or other senior executive for financial matters, without regard to title) in his or her discretion.

B. A determination of qualification for financial assistance will cover services provided by the Hospital on an inpatient or outpatient basis. For these purposes, the policy also covers the rendering of professional services by physicians and other providers employed directly by the Company, as listed on **Exhibit 4**. A determination of qualification for financial assistance will also cover professional services rendered by the other physicians and providers set forth on **Exhibit 5**, all of whom participate in the provision of emergency and/or medically necessary behavioral health services at the Hospital and have agreed to be covered by this policy. Any other physicians or providers of care at the Hospital are not subject to this policy and, accordingly, each patient will be responsible for satisfaction or resolution of any bills issued by such physicians or providers for their professional services.

C. Where possible, prior to the admission or rendering of service, a Financial Counselor will conduct an interview with the patient, the guarantor, and/or his other legal representative. If an interview is not possible prior to the admission or rendering of service, the interview should be conducted upon admission or as soon as possible thereafter. In the case of an emergency admission, the evaluation of payment alternatives may not take place until the required behavioral health services have been provided.

D. At the time of the initial patient interview, the Financial Counselor will gather routine demographic information and information regarding all existing third-party coverage. In cases where a patient has limited or no third-party coverage, the Financial Counselor will determine if the patient qualifies for medical assistance from other existing financial resources such as Medicare, Medicaid, or other state and federal programs. The Financial Counselor will be available to assist the patient with enrolling in any governmental payment programs that may be available. If the patient refuses to apply for or provide information necessary to the application process, he or she will be ineligible for financial assistance pursuant to this policy. If the application(s) to the above-mentioned medical financial assistance resource(s) is (are) denied, not adequate,

or was (were) previously denied, consideration for financial assistance will then be given.

E. In cases where third-party coverage (including private insurance or payment by governmental program) is nonexistent or likely to be inadequate, the Financial Counselor will inform the patient of the availability of Financial Assistance. Patients seeking financial assistance will be asked to complete the Financial Assistance Application attached as **Exhibit 3** to this policy. Copies of the application form are available from any Financial Counselor and at *www.southcoastbehavioral.com*. Applications may be completed directly by the patient, by the patient's guarantor and/or other legal representative, or by a Financial Counselor based on information derived from any of the foregoing through an interview either in person or by telephone, or reliable information provided in writing. If assistance is needed with gathering necessary information or materials requested as part of the Financial Assistance qualifying process, patients are encouraged to contact one of the Hospital's trained Financial Counselor at (508)207-9800. Financial Counselors may also assist patients with assessing their financial situations, gathering information requested by the Hospital, and assisting with similar tasks.

F. Patients completing the Financial Assistance Application must submit the signed form and supporting materials to the Hospital through any of the following measures:

- Hand-delivering the materials to a Patient Service Representative; to the Business Office at the Hospital, *581 Faunce Corner Road, Dartmouth, MA 02747*
- Mailing the materials to Southcoast Behavioral Health, Attn: Business Office, *581 Faunce Corner Road, Dartmouth, MA 02747*
- E-mailing the materials to *Financial.Counselor@southcoastbehavioral.com*

Financial Assistance Applications will be considered if received at any time during the 240-day period following the first post-discharge billing statement issued by the Hospital to the patient for such care.

G. Eligibility for financial assistance is conditioned upon the patient's provision of complete and accurate information on the Financial Assistance Application set forth as **Exhibit 3**, and the patient's timely cooperation throughout the financial assistance application process. In connection with determining a patient's eligibility for financial assistance, the Hospital will not request information other than as described on **Exhibit 3**, although patients may voluntarily provide additional information that they believe to be pertinent to eligibility. If the Hospital contacts the patient to request missing information, the patient will have a period of 30 days to respond. Failure to respond within that 30-day period will result in the Application being suspended from further processing; the patient may re-activate the Application by providing the requested information at any time during the 240-day period following the first post-discharge statement issued by the Hospital to the patient for such care. If a patient provides

information that is inaccurate or misleading, he or she may be deemed ineligible for financial assistance and, accordingly, may be expected to pay his or her bill in full.

H. Once a completed Financial Assistance Application is received, the Financial Counselor will review the application and forward it to the *Business Office Director*. Patients who are determined to be presumptively eligible as described in Section IV.I., will be processed for financial assistance without need for completion of the Financial Assistance Application.

I. Patients who are uninsured and who do not qualify for financial assistance may contact the Hospital to discuss payment options, including the availability of a payment plan. Financial Counselors will inform such patients of any other discounts that may be available under other Hospital policies.

VI. Determination and Notification Regarding Financial Assistance:

A. In the case of patients who are determined to be financially eligible for financial assistance, patients with family income at or below 200% of the current Federal Poverty Guidelines will receive a 100% reduction in the patient portion of billed charges (*i.e.*, full write-off), as set forth on **Exhibit 1**. Patients with family income between 201% and 350% of the current Federal Poverty Guidelines will receive a sliding-scale discount on the patient portion of the billed charges, as indicated on **Exhibit 1**. In the case of patients who are determined to be medically indigent, the appropriate discount will be determined by the Business Office Director and the Chief Financial Officer after review on a case-by-case basis. Patients who are determined to be presumptively eligible for financial assistance will receive a 100% reduction in charges (full write-off).

B. The applicable discount percentage from **Exhibit 1** will be applied to the gross charges otherwise billable to the patient. Such discounts have been established in a manner intended to comply with applicable Federal law, which prohibits the Hospital from billing a patient eligible for financial assistance more than the amounts generally billed ("AGB") by the Hospital to patients with third-party coverage, calculated in this case using the look-back method set forth in applicable Treasury Regulations, considering amounts allowed by Medicare and commercial payors during a prior 12-month measurement period. The discount percentages set forth on **Exhibit 1** may be adjusted periodically (and at least annually) to ensure that such percentages comply with the foregoing standards under Federal law; any such adjustments will be effectuated through the attachment of an updated **Exhibit 1** to this Policy, which will be signed and dated by the Hospital's Chief Financial Officer. The Hospital will begin applying the adjusted discount percentages not later than 120 days after the end of the 12-month measurement period with respect to which the Hospital's adjusted AGB has been calculated.

C. The provision of financial assistance (*i.e.*, the amount of the discount or write-off) of under $5,000 may be approved by a Financial Counselor. The provision of financial assistance of $5,000 or more will require the approval of the Business Office Director.

The provision of financial assistance of $20,000 or more will also require the approval of the Hospital's Chief Financial Officer.

D. Within 30 days after submission of a completed Financial Assistance Application, the Hospital will determine whether the patient qualifies for financial assistance based on financial eligibility or medical indigence and will notify the patient in writing of such determination and the amount of the discount to be provided. Unless otherwise determined by the Chief Financial Officer, the Hospital need not notify patients determined to qualify for financial assistance based on presumptive eligibility. In the event that the Hospital determines a patient *not* to qualify for financial assistance, the Hospital will notify the patient in writing of such determination, including the basis for the denial.

E. Except as provided below, all determinations of qualification for financial assistance will continue in effect for 6 months from the first date of services subject to the determination. Accordingly, if a patient has qualified for financial assistance within the last 6 months and the patient's financial circumstances, family size, and insurance coverage have not changed, the patient will be deemed to have qualified for financial assistance with respect to additional emergency or medically necessary behavioral health services, without having to submit a new Financial Assistance Application. However, if a patient has qualified for financial assistance but then experiences a material change in his or her financial circumstances and/or insurance status that may impact his or her continued qualification for financial assistance, the patient will be expected to communicate that change to the Hospital within 30 days or, in any event, prior to obtaining further behavioral health services. Alternatively, the Hospital may request an update of the information provided on the Financial Assistance Application and, based on such updated information, may re-evaluate the patient's continued qualification.

VII. Impact on Billing and Collection Process:

A. Patients qualifying for discounted, but not free, care will be notified in writing regarding any remaining balance due. The patient may be asked to schedule an appointment with a Financial Counselor to arrange payment terms. Any such remaining balances will be treated in accordance with Business Office policies regarding self-pay balances, and such balances will be sent to a third-party collection agency within 90-120 days after patient discharge. Payment terms will be established on the basis of disposable family income.

B. In the event that a patient qualifies for financial assistance but fails to timely pay the remaining balance due (including, if applicable, per the terms of the agreed-upon payment plan), the Hospital may take any of the actions set forth in the Hospital's Billing and Collection Policy, a copy of which is available at *southcoastbehavioral.com,* including sending remaining self-pay balances to a third party collection agency within 90-120 days of patient's discharge date. Consistent with the Billing and Collection Policy, the Hospital will not undertake any extraordinary

collection actions (as defined in that Policy) without first making reasonable efforts to determine a patient's eligibility for financial assistance pursuant to this policy.

VIII. Publication:

A. The Hospital seeks to ensure that information regarding the existence and terms of this Financial Assistance Policy is made widely available to residents of the geographic areas served by the Hospital. In furtherance of the foregoing, the Hospital will utilize and widely distribute the plain-language summary attached as **Exhibit 6** to this Policy. Copies of such plain-language summary (i) will be included in patient registration materials and inpatient handbooks, (ii) will be offered to each patient as part of the intake or discharge process, and (iii) will be posted on the Hospital's website, along with this Policy and the Financial Assistance Application, in a prominent and easily accessible location. The plain-language summary will be available in English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital's service area.

B. The Hospital will conspicuously post in the admissions department signage providing information regarding the availability of financial assistance and describing the application process. Such signage will include the following statement: *You may be eligible for financial assistance under the terms and conditions the Hospital offers to qualified patients. For more information, contact the Financial Counselor at (508)207-9800.* Such signs will be in both English and any other language that is the primary language of the lesser of (i) 1,000 individuals, or (ii) 5% of the population within the Hospital's service area. Such signage may be posted in other areas throughout the Hospital offering meaningful visibility.

C. The Hospital will cause each billing statement sent to a patient to include a conspicuous statement regarding the availability of financial assistance, including (i) a phone number for information about this policy and the application process, and (ii) a website address where this policy, the Financial Assistance Application, and the plain-language summary are available. As provided in the Billing and Collection Policy, if the Hospital intends to undertake any extraordinary collection action (as defined in the Billing and Collection Policy), the Hospital will ensure that at least one billing statement includes a copy of the plain-language summary of this Financial Assistance Policy, as set forth on **Exhibit 6**, with such copy provided at least 30 days prior to undertaking the anticipated extraordinary collection action.

IX. Budgeting, Recordkeeping, and Reporting:

A. The Chief Financial Officer will ensure that reasonable financial assistance, including both free care and discounted charges, is included in the annual operating budget of the Hospital. The budgeted amount will not act as a stopping point in providing financial assistance, but will serve as a projection to aid in planning for the allocation of resources.

B. The Hospital will cause completed Financial Assistance Applications (along with required supporting information) to be maintained in Business Office records. Such records will also reflect information as to whether such applications were approved or denied, along with the handling of any requests for reconsideration.

C. Financial assistance provided by the Hospital pursuant to this Policy will be calculated and reported annually as required under applicable law. Except as otherwise specifically permitted based on context, the Hospital will report its financial assistance provided to qualifying patients under this policy using the actual cost of services provided based on the total cost-to-charge ratio derived from the Hospital's Medicare cost report (and not the actual charges for the services).

X. Confidentiality:

The Hospital recognizes that the need for financial assistance may be a sensitive and deeply personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance pursuant to this Policy. No information obtained in the patient's financial assistance application may be released except where authorized by the patient or otherwise required by law.

XI. Staff Information/Training:

A. The Hospital will cause all employees in the Business Office and Patient Admitting and Registration areas to be fully versed in this Financial Assistance Policy, to have access to this Policy as well as the plain-language summary and Financial Assistance Application forms, and to be able to direct questions to the appropriate Hospital office or representative.

B. The Hospital will cause all staff members with public and patient contact to be adequately trained regarding the basic information related to this Financial Assistance Policy and procedures. They will also be able to direct questions regarding this Policy to the appropriate Hospital office or representative.

XII. Other Related Policies:

A. Billing and Collection Policy
B. *[insert]*

Attachments:

Exhibit 1 Financial Assistance Guidelines
Exhibit 2 Patient Decision Power Release Form
Exhibit 3 Financial Assistance Application
Exhibit 4 Company-Employed Physicians and Providers Covered by Policy
Exhibit 5 Other Physicians and Providers at Hospital Covered by Policy
Exhibit 6 Plain-Language Summary of Financial Assistance Policy

EXHIBIT 1

Financial Assistance Guidelines

Family or Household Size	100% of 2024 FPG	200% of 2024 FPG	300% of 2024 FPG	350% of 2024 FPG
	Free Care	***Free Care***	***75% Discount***	***50%** Discount***
1	$15,060	$30,120	$45,180	$52,710
2	20,440	40,880	61,320	71,540
3	25,820	51,640	77,460	90,370
4	31,200	62,400	93,600	109,200
5	36,580	73,160	109,740	128,030
6	41,960	83,920	125,880	146,860
7	47,340	94,680	142,020	165,690
8*	52,720	105,440	158,160	184,520

* Add $5,380 for each additional person above 8 household occupants

** The foregoing discount percentage has been established in a manner intended to comply with applicable Federal law, which provides that the Hospital may not bill a patient eligible for financial assistance more than the amounts generally billed ("AGB") by the Hospital to patients who have insurance covering such care. The Hospital has calculated its AGB using the look-back method set forth in applicable Treasury Regulations, considering amounts paid by Medicare and commercial payors. Such calculation resulted in the following:

Measurement period	*October 1, 2023 – September 30, 2024*
AGB	62%

The Hospital will recalculate its AGB periodically (and at least annually) and, based thereon, will adjust the discount percentages set forth above. Any such adjustments will be effectuated through a revision to this **Exhibit 1**, which will be signed and dated by the Hospital's Chief Financial Officer.

Signed: Jocelyn De Souza
Print Name: Jocelyn De Souza
Date: 7/16/2024

EXHIBIT 2

Decision Power Release Form

Name of Patient/Guarantor Patient Account #

Social Security Number Date of Birth

Employer _____ Phone _____

Gross monthly income $_____
Any additional Source of income (child support/alimony) $_____

Total Monthly Gross Household Income (Proof of income required) $_____

Number of dependents including Self: _____

Housing: Own ____ Rent _____ Monthly payment $_____

Do you have any of the assets listed below? If so, please provide details.

Yes ___ No ___ Checking account $_____
Yes ___ No ___ Savings account $_____
Yes ___ No ___ Money Market Fund $_____

Please list any other financial information to be considered in determining your ability for payment:

_____

_____

Cobra eligible? Yes or No If yes, insurance company _____ premium _____

To receive healthcare at a reduced cost to you, you must cooperate fully with our need for accurate and detailed financial information, including the timely production of necessary documentation to support this disclosure. Completion of the Financial Disclosure Form does not guarantee that you will be eligible for a cost reduction in your healthcare.

I authorize representatives of (Facility Name) and its affiliates to verify the information on this form and to release any of my information for payment purposes. The information given above is true and complete. I agree to notify (Facility Name) of any changes in my financial situation. I further authorize (Facility Name) and its affiliates to review and inquire into my credit history using any means available, including using a report provided by a national Credit Bureau.

Signed _____ Date _____

Witness _____ Date _____

EXHIBIT 3

Financial Assistance Application

FINANCIAL ASSISTANCE PROGRAM

As part of our mission, Southcoast Behavioral Health is committed to providing the public with access to quality behavioral health services, and to treating all our patients with dignity, compassion and respect.

Our Financial Assistance Program provides services without charge, or at significantly discounted prices, to eligible patients who cannot afford to pay for part or all of their care. Our Financial Assistance Program provides discounts up to 100 percent of hospital/physician charges to patients who meet financial eligibility guidelines.

When applying for Financial Assistance, your cooperation is needed in providing the information and supporting documentation necessary for us to make a fair and timely decision. If complete and accurate information is not provided, your application may be rejected or denied without further review, in which case you will be expected to pay your bill in full.

Given the sensitive nature of these requests, all communication with the patient or family members will be handled in strict confidence and in a compassionate manner.

Copies of this application form are available in [English and Spanish].
Copias de la solicitud de asistencia financiera están disponibles en Inglés y Español.

This Financial Assistance Application is being provided to you for completion so that we can determine if you qualify for our Financial Assistance Program.

COMPLETING THIS FORM IS NOT A GUARANTEE OF ELIGIBILITY

If you do not complete this application packet or if you return it without the requested supporting documentation, we will be unable to determine whether you qualify for our Financial Assistance Program. In that case, you will be responsible for the full balance due on your account.

If you need help in completing this form or gathering the supporting materials, please contact the Financial Counselor at *(508)207-9800*.

To determine if you qualify for our Financial Assistance Program, please return the following supporting documentation with this completed packet:

- ✓ A copy of a photo ID (state driver's license/state ID).
- ✓ Last year's Form 1040 federal income tax return, with all Forms W-2 and/or 1099.
- ✓ Last two weeks of paystubs with year to date totals, or last two months of paystubs without year to date totals (if paid in cash without paystubs, provide written verification from employer).
- ✓ Proof of income from all other sources such as unemployment compensation, disability income, rental income, pensions, annuities, interest payments, etc.
- ✓ If you are currently receiving Social Security benefits, a copy of your "benefit amount" letter.
- ✓ Copies of bank statements for checking, savings, certificates of deposit, etc. for the last two months.
- ✓ A copy of a current utility bill, telephone bill, or cable television bill from the residence at which you reside.
- ✓ If you are a student, a list of the current semester's credits/classes and a copy of your student ID.

☞ NOTE: The name shown on the patient's photo ID must be the same name shown on paystubs and tax forms.

Please return this completed application and the requested supporting documentation as soon as possible. An application will not be reviewed until all required supporting documentation has been provided.

The Patient Protection and Affordable Care Act requires all individuals to have health insurance coverage effective as of January 1, 2014. Our Financial Counselors will provide you with information as to how you can apply for health insurance coverage through the federal insurance exchange at "www.marketplace.gov" and can help you with the enrollment process.

FINANCIAL ASSISTANCE APPLICATION

(PLEASE PRINT – BE SURE TO PROVIDE ALL REQUESTED INFORMATION)

I. PERSONAL INFORMATION

Personal information of applicant (or parent, if applicant is a minor):

Name _____ Date of Birth _____
Last First MI

Address _____
Street City State Zip Code

Living at Address Since _____ Phone # (_____) _____ Social Security # _____

Marital Status: Single _____ Married _____ Divorced _____ Widow _____

Spouse's Name _____ Spouse's Social Security # _____ Date of Birth _____

☞ **If credit report indicates high risk, a copy of your social security card(s) will be required.**

List family members (including parents, patient, and natural or adoptive siblings) living at above address.

FAMILY MEMBER'S LEGAL NAME	DATE OF BIRTH	RELATIONSHIP TO PATIENT
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

II. INSURANCE INFORMATION

	APPLICANT (OR PARENT, IF APPLICANT IS A MINOR)	APPLICANT'S SPOUSE
Do you have health insurance? (Y/N)		
If yes, name of health insurance plan:		
Medicare? (Y/N)		
Medicare Part D? (Y/N)		
Medicare Supplement? (Y/N)		
Medicaid? (Y/N)		
Veteran's Benefits? (Y/N)		

III. EMPLOYMENT AND INCOME INFORMATION

Employment information of applicant (or parent, if applicant is a minor):

Employer _____ Unemployed? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position _____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This Semester _____

MONTHLY SALARY			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

Additional Source(s) of Income (per month):

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ Farm Income	$_____		

Employment information of Spouse (if applicable):

Spouse's Employer _____ Unemployed ? (Y/N)____ Date of Unemployment _____

Business Address _____
Street City State Zip Code

Phone # (_____) _____ Does Employer Offer Health Insurance ? (Y/N) _____

Occupation / Position_____ Date of Hire _____

Student (Y/N)_____ Name of School_____ Number of Credits This semester _____

MONTHLY SALARY			
GROSS	$	NET	$

HOURLY PAY	$	HOURS WORKED WEEKLY	

Additional Source(s) of Income (per month):

❑ Other wages	$_____	❑ Child Support	$_____	❑ Self Employment	$_____
❑ Interest, Dividends	$_____	❑ Pension/Ret'mt	$_____	❑ SSI/Social Security	$_____
❑ Rental Income	$_____	❑ Worker's Comp	$_____	❑ Veterans Benefits	$_____
❑ Food Stamps	$_____	❑ Unemployment	$_____	❑ Other	$_____
❑ Alimony	$_____	❑ Farm Income	$_____		

IV. MONTHLY EXPENSE INFORMATION

Indicate monthly amounts paid or owed on items below:

RENT / MORTGAGE		**HOUSEHOLD BILLS**	
Landlord Name		Heat / Utilities	$
Landlord Phone #	( )	Phone / Cell Phone	$
Mortgage Lender		Cable TV / Internet	$
Mortgage Amount	$	Homeowner's Insurance	$
		Auto Insurance	$
LOANS		Health, Dental, Vision Insurance	$
Auto Loans	$	Life or Disability Insurance	$
Personal Loans	$	Other Insurance	$
Student Loans	$	Medical Bills (hospital / clinic)	$
OTHER OBLIGATIONS		**CREDIT CARDS**	
Child Care	$	Credit Card	$
Child Support	$	Credit Card	$
Alimony	$	Credit Card	$
Other	$		

TOTAL MONTHLY EXPENSES: $_____

V. ASSETS

Indicate current fair market value of any of the following:

BANK ACCOUNTS		**REAL ESTATE OWNED**	
Name of Bank		Value	$
Savings	$	Street Address	
Checking	$	City, State and ZIP	

VEHICLES OWNED				**LIST OTHER ASSETS**	
	Year/Make	Model	Value		$
First			$		$
Second			$		$
Third			$		$

TOTAL ASSETS: $_____

VII. CERTIFICATION

I certify that the information I have provided in this application and the required supporting documentation is true and correct to the best of my knowledge. I will apply for any federal, state or local assistance for which I may be eligible to help pay for my medical care. I understand that, if I knowingly provide inaccurate or incomplete information in this application, I may be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of my medical bills.

Applicant's Signature _____ Date of Request_____

Your completed application and supporting documentation may be submitted by:

- Hand-delivering the materials to a Patient Service Representative or to the Business Office at the Hospital, *581 Faunce Corner Road, Dartmouth, MA 02747*
- Mailing the materials to Southcoast Behavioral Health, Attn: Business Office, *581 Faunce Corner Road, Dartmouth, MA 02747*

EXHIBIT 4

Company-Employed Physicians and Other Providers Covered by Policy

First	M.	Last	Practice Name
Gyula		Bokor	Southcoast Behavioral Health
Rodica		Brisan	Southcoast Behavioral Health
Robert		Doyle	Southcoast Behavioral Health
William		Drexel	Southcoast Behavioral Health
John		Findley	Southcoast Behavioral Health
Gregory		Gass	Southcoast Behavioral Health
Melady		Genereux	Southcoast Behavioral Health
Allan		Giesen	Southcoast Behavioral Health
Frank		Kahr	Southcoast Behavioral Health
Michael		Liebowitz	Southcoast Behavioral Health
Ryan		Perry	Southcoast Behavioral Health
Michael		Rater	Southcoast Behavioral Health
Dani		Ray	Southcoast Behavioral Health
Wendy		Rayne	Southcoast Behavioral Health
Barbara		Roderick	Southcoast Behavioral Health
Shavanese		Sommerville	Southcoast Behavioral Health
Tammy		Young	Southcoast Behavioral Health

EXHIBIT 5

Other Physicians and Providers Providing Care at the Hospital Covered by this Policy

First	M.	Last	Practice Name

EXHIBIT 6

Plain-Language Summary of Financial Assistance Policy

Southcoast Behavioral Health will provide emergency and medically necessary healthcare services for free or at discounted rates to patients who are uninsured or have limited insurance available. Generally speaking, patients eligible for discounted charges must have family incomes under 350% of the Federal Poverty Guidelines, while patients eligible for free care must have family incomes under 200% of the Federal Poverty Guidelines. Financial assistance may also be available in other limited circumstances, depending on the size of the patient's medical bills and whether the patient meets certain other criteria for eligibility.

Patients seeking financial assistance may apply by completing a Financial Assistance Application. Copies of the Financial Assistance Application, as well as the Hospital's Financial Assistance Policy and Billing and Collection Policy, are available at *www.southcoastbehavioral.com.* Patients may also request free copies of the Financial Assistance Application and the foregoing policies by mail, by calling the Financial Counselor at *(508)207-9800*, or may obtain free copies in person at the Hospital's Business Office, *581 Faunce Corner Road, Dartmouth, MA 02747*. The Financial Assistance Application and the foregoing policies (as well as this plain-language summary) are available in *English, Spanish, and Portuguese*.

Completed Financial Assistance Applications and supporting materials should be submitted to Southcoast Behavioral Health, Attn: Business Office, *581 Faunce Corner Road, Dartmouth, MA 02747*. Applications may be delivered in person to the Business Office. Applications also may be sent by U.S. mail to the address indicated above.

Persons seeking more information or needing assistance in completing the Financial Assistance Application may contact one of the Hospital's trained Financial Counselors in the Business Office at *(508)207-9800*.

A patient qualifying for financial assistance under the Hospital's Financial Assistance Policy with respect to emergency or medically necessary behavioral health services will not be charged more than the amounts generally billed by the Hospital for the same services to individuals who have insurance covering such care.