

LAKE REGION HEALTHCARE SELF PAY DISCOUNT PROGRAM TERMS AND CONDITIONS

WHAT IS THE SELF-PAY DISCOUNT PROGRAM?

It is the policy of Lake Region Healthcare that all patients at Lake Region Healthcare receive quality medical care regardless of ability to pay. The Lake Region Healthcare Self-Pay Discount Program (LRHSPD) is designed to assist patients who do not have insurance available to pay for medically necessary healthcare treatment and do not qualify for Minnesota Care, Medicaid, Medical Assistance, or other public assistance programs. The LRHSPD addresses the needs of patients for Uninsured Treatment whose annual household income is less than \$125,000.00. The LRHSPD is not an insurance program, and is not meant to replace benefits that are, or could be, received from third party payors or government-supported programs. Persons seeking to utilize the LRHSPD must meet the eligibility requirements of the program and all third party payor resources and non-hospital financial aid programs must be determined to be unavailable prior to applying for the LRHSPD.

WHO IS ELIGIBLE?

The LRHSPD is available only to patients whose annual gross household income is verified as less than \$125,000.00, and who do not have insurance, third party payor resources or government-supported programs to cover Lake Region Healthcare charges. Participants must submit an LRHSPD application and supporting materials, meet the eligibility requirements, and comply with the LRHSPD guidelines.

WHAT SERVICES ARE ELIGIBLE FOR THE DISCOUNT?

The LRHSPD is only available for Lake Region Healthcare charges for "Uninsured Treatment." The term Uninsured Treatment means any medically necessary health care treatment or services which are not covered by a plan, contract, or policy which provides coverage to the patient through or is issued to the patient by: (1) a "health plan company," as that term is defined in Minn. Stat. § 62Q.01, Subd. 4; (2) a self-funded employee benefit plan; (3) any governmental program, including but not limited to MinnesotaCare, the Minnesota Comprehensive Health Association, Medicare, Medicaid, or TriCare; (4) any other type of health insurance, health maintenance, or health plan coverage; (5) any other type of insurance coverage, including but not limited to no-fault automobile coverage, workers' compensation coverage, or liability coverage. The LRHSPD is applicable only to charges for medically necessary healthcare treatment and not for cosmetic or elective procedures without any medical necessity. The LRHSPD is available only for services or materials provided directly by Lake Region Healthcare.

WHAT IS THE APPLICATION PROCESS FOR THE LRHSPD?

An uninsured, self pay patient will receive a detailed, itemized bill from Lake Region Healthcare as part of the billing process. When it is determined that a patient does not have insurance, third party payor resources or government-supported programs to cover Lake Region Healthcare charges for medically necessary health care treatment, the Lake Region Healthcare business department will begin the eligibility determination process for the LRHSPD once a patient submits a completed application form (Attached), along with income verification documents. Failure to complete the application or provide the income verification documents will result in the LRHSPD not being available. A patient must provide income documentation such as recent tax statements, pay stubs, employer salary history, etc. with the application. The Lake Region Healthcare business office will process applications and may need to contact patients or third parties and request additional information. Once the eligibility process is complete, a patient will receive notification from Lake Region Healthcare in the mail. An eligible patient will receive a bill showing the charges, the amount of the discount, and the amount due. For patients who qualify for the discount, the application will constitute a written agreement to pay the amount of the charges remaining after making the applicable deduction under the LRHSPD.

Application for Self-Pay Discount

Patient Account Number _____

I hereby request Lake Region Healthcare to make a determination of eligibility for the LRHSPD. I understand that the information submitted on this application and the documentation I submit to verify household income is subject to verification by Lake Region Healthcare. This application is made pursuant to the terms and conditions of the LRHSPD as described in the foregoing informational statement. I represent to Lake Region Healthcare that I do not have any insurance, third party payor resources or government-supported programs to cover Lake Region Healthcare charges. I understand the LRHSPD is available only for medically necessary health care treatment.

PATIENT AND HOUSEHOLD MEMBER INFORMATION

Name of Patient _____ Patient D.O.B. _____

Name of Applicant _____

Address _____ Phone _____

Applicant's Occupation _____ Employer _____

Employer's Phone _____ Employer Contact _____

Gross Annual Income _____

Name of Spouse _____

Spouse's Occupation _____ Spouses Employer _____

Employer Phone _____ Employer Contact _____

Gross Annual Income _____

Applicant Social Security # _____ Spouses Social Security # _____

Name and Age of All Household Members

Other Household member(s) occupation _____

Employer _____ Phone _____

Employer Contact _____ Gross Annual Income _____

Employer _____ Phone _____

Employer Contact _____ Gross Annual Income _____

Employer _____ Phone _____

Employer Contact _____ Gross Annual Income _____

DISCLOSURE OF ALL HOUSEHOLD INCOME

Income is the total of all household member earnings, income and money receipts before taxes from all sources including wages, salaries, unemployment, social security, alimony, investments, rents, public assistance, self-employment, farm or business, etc.

INCOME: Gross Income for Household: Income from all members of the household must be included.

Wages (before taxes)	_____
Farm or Self-employment	_____
Public Assistance	_____
Social Security	_____
Unemployment Compensation	_____
Worker's Compensation	_____
Disability	_____
Alimony	_____
Child Support	_____
Pensions	_____
Income from Dividends, Interest, Rent	_____
Other Sources of Income.	_____
TOTAL ANNUAL HOUSEHOLD INCOME	_____

Please provide the following income verification documents for each applicable family member and sign the certification statement below:

- 1) Copy of the most recent Federal tax return (1040)
- 2) Copy of 3 months of most recent pay stubs for all employed family members or self-employment income
- 3) Copy of 3 months of most recent checking and/or savings bank statements

I certify that the information in this application is true and correct to the best of my knowledge. I understand that the information provided may be verified by Lake Region Healthcare, and I authorize Lake Region Healthcare to contact third parties to verify the accuracy of the information provided in this application. I understand that if I knowingly provide untrue information in this application, I will be ineligible for financial assistance, any financial assistance granted to me may be reversed, and I will be responsible for the payment of the bill(s).

UNDERSIGNED AGREES THAT THIS APPLICATION CONSTITUTES A WRITTEN AGREEMENT BY APPLICANT TO PAY THE AMOUNT OF THE CHARGES REMAINING AFTER MAKING THE APPLICABLE DEDUCTION UNDER THE LRHSPD, IF THE LRHSPD IS AWARDED.

Applicant's Signature: _____ Date: _____