Healthcare Expenses ReLief Program (HELP)

Helen Newberry Joy Hospital & Healthcare Center will make available limited discounted services to the uninsured/underinsured. A sliding fee scale determines applicant's responsibility for Helen Newberry Joy Hospital's physician and facility charges covered by program.

Helen Newberry Joy Hospital Qualified Services

- Inpatient and Outpatient services provided by Helen Newberry Joy Hospital. Excluding professional fees for services provided by independent physicians contracted by Helen Newberry Joy Hospital. Professional fees incurred in Emergency Department are not excluded.
- Professional services provided at Gibson Family Health Center, West Mackinac Health Clinic, Manistique Lakes Family Clinic, and Newberry Provider Based Clinic.

Services Not Included Under This Program

- Any service provided by independent physicians that are contracted by Helen Newberry Joy Hospital, visiting Specialty Clinics or Optical Clinic/Shop are not covered.
- Pulmonary Function Test (PFT) readings (unless read by HNJH employed physician) and virtual radiology tests are not covered. Radiology test interpretations and Pathology readings are not covered.
- Elective, preventive, or screening services are not covered (i.e., annual wellness visits or related tests.)
- The Wellness Center and certain medical equipment/supplies are not covered.
- Any services that are offered at the Health Department, Tribal Center or any health institution that the HELP recipient is eligible for by grant or sliding fee scale, are not covered.
- Immunizations are not covered.
- This is **NOT** an insurance program. Therefore, we cannot apply a sliding-fee scale to services offered by any other providers or facilities. This program covers services rendered at HNJH, other facilities excluded.
- In the event that there is a third party payer, (Workman's Compensation, Auto Insurance, or Homeowner's Insurance) ALL services related to the third party incident are NOT covered by the HELP program. The HELP recipient is financially responsible for all services related to the third party incident. It is the HELP recipient's responsibility to seek reimbursement or have the third party payer pay HNJH directly for services pertaining to the incident. Exceptions to the third party, when a deductible and a co-insurance are remaining the patient balance could then qualify as under-insured.

Individual Written Notice to Patient

The Healthcare Expenses Relief Program can be applied for either before or after a patient has received care. However, the patient is encouraged to apply for the program before non-emergent services to benefit from the sliding fee scale. Upon completed application and determination of eligibility, services 90 days before eligibility date and extended up to one year after may apply to a sliding fee scale. The current income requirements are:

Family Size			
1	$30,350.00	5	$73,550.00
2	$41,150.00	6	$84.350.00
3	$51,950.00	7	$95,150.00
4	$62,750.00	8	$105,950.00

Instructions for Healthcare Expenses Relief Program Applicants

- Complete the Healthcare Expenses ReLief Program Application on the back of this form.
- Provide proof of household income. Include copy of income tax return and the most current 30 days of check stubs. You may be required to complete & submit the following forms upon request: Affidavit of Living Arrangements, include most recent bank statements, income tax affidavit, IRS Form 4506T, and verification of tax transcript.
- Return application and above items to Patient Accounts, Helen Newberry Joy Hospital 502 W. Harrie St. Newberry MI 49868 (906)293-9115 or (906)293-9123.
- You may be required to apply for Medicaid/Medicare and provide valid Medicaid/Medicare rejection letter. You will be required to sign an affidavit verifying all information is current and accurate. If you do not feel you may qualify for assistance due to income guidelines, please contact the above Financial Counselors for other resources that may be available. Revised

HEALTHCARE EXPENSES RELIEF PROGRAM

Sliding Fee Application

DATE OF REQUEST:

Last Name______________________________ First__________________ M.I.__________

Address________________________________ City, State, Zip ________________________

Social Security#_________________________ Date of Birth__________________________

Home Phone#___________________________ Cell Phone#___________________________

Name of Employer_______________________ Work Phone# _________________________

Spouse's First Name_____________________ M.I. __________________________________

Social Security#_________________________ Date of Birth__________________________

Name of Employer_______________________ Work Phone# _________________________

Household Size (include yourself) _____

List Each Household Member's Name/Age

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List Each Household Member's Name/Age

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List below description of income (monthly)/assets amount for household

Income _______________ $__________

Checking _______________ $__________

Savings _______________ $__________

Income_________________ $__________

Other _________________ $__________

_________________ $__________

Are you eligible for VA, Tribal, or other resources? If so, please provide details.

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I understand that the information, which I submit, is subject to verification by Helen Newberry Joy Hospital & Healthcare Center, and subject to review by federal/state enforcement agencies and others as required. I certify that the above information is a full, accurate description of the facts. Furthermore, I authorize Helen Newberry Joy Hospital to release/transfer information to the Community Health Access Coalition at 505 Washington Blvd. Newberry, MI 49868 to facilitate the intake process.

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Signature of Person Making Request