Guarantor Name:_____

Memorial Hospital
OF SWEETWATER COUNTY

Dear Sir/Madam:

Our records indicate that you did not have health insurance coverage or that you had limited insurance or entitlement program coverage at the time services were rendered by personnel at Memorial Hospital of Sweetwater County.

Our hospital provides services at no cost or at a reduced cost to qualifying applicants who meet our Medical Assistance guidelines.

Please find the program guidelines on the reverse side of this document and the attached application for the program. If you feel that you qualify, please complete the application and submit the required proof of your income to the hospital's Patient Financial Services department within 15 days.

Please provide our Patient Financial Services personnel with the information that pertains to your financial situation. This information will allow us to determine if you qualify for the program: Please provide personnel at our facility with the information that pertains to your financial situation:

- ☐ **1.** A completed copy of your most recent income tax return (1040) along with the associated W2 forms. Or a copy of your 1099 and Award Benefit Letter from Social Security.
- ☐ **2.** Copies of your most recent payroll information with YTD totals from all employers for the current year, or a written statement from your employers indicating your gross YTD earnings. If retirement is checked provide a statement showing total retirement account balance.
- ☐ **3.** Printouts from all agencies that you have received benefits from over the last twelve months. Examples include: Food Stamps, Lieap, ERAP, Unemployment, AFDC, Worker's Compensation, Financial Aid information pertaining to secondary schooling, etc.
- ☐ **4.** If you receive child support, a printout from the Clerk of Court indicating the monthly child support that you receive.
- ☐ **5.** Letters from friends or family members who assist you with your financial needs, explaining the assistance they provide for you.
- ☐ **6.** Copy of your legal Decree of Divorce if children are considred part of the applicant's family unit.
- ☐ 7. Copies of your most recent offical copy of investment and bank statements. Consecutive 30 day print out.
- ☐ **8.** If you reside in subsidized housing, a copy of your rental agreement.
- ☐ **9.** Proof that you were domiciled in Sweetwater County for 120 days prior to the date of service. ie., drivers license, vehicle registration, utility bills, bank statements, etc.
- ☐ **10.** All applicants must show proof of applying for **Wyoming Medicaid**. Please call **1-855-294-2127** and provide reference/case number after applying.

Please call and make an appointment with our Patient Financial Navigators once you have everything together and ready to turn in your application. You can reach Megan or Melida, our Financial Navigators at 307-352-8202. We are happy to discuss everything that is needed in order to process your application and explore other avenues to help retire your debt at Memorial Hospital of Sweetwater County.

P.O. Box 1359 ~ Rock Springs, WY 82902 ~ 307-362-3711 ~ 307-352-8202

Memorial Hospital
OF SWEETWATER COUNTY

MEDICAL ASSISTANCE PROGRAM

APRIL 2020 THROUGH APRIL 2021

Memorial Hospital of Sweetwater County provides services to qualifying patients and who are domiciled in Sweetwater County prior to the date of service, at no cost or at a reduced cost in an effort to help patients that do not have the ability to pay for hospital services. If you believe that you are eligible for our medical assistance program, please complete the assitance application, attach the required proof of your savings, investments, household income, proof that the patient was domiciled in Sweetwater County at least 120 days prior to the date of service, and proof of application to Wyoming Medicaid if requested, and deliver it to the Patient Financial Services department at 1200 College Dr., Rock Springs, WY. Please note that all applicants are required to provide verification of their family unit income, savings, investments, and residency at the time of service, and authorize Memorial Hospital of Sweetwater County to verify any and all information before the application will be processed and a determination made.

1. Medical Assistance may be used for most services provided by Memorial Hospital of Sweetwater County. The assistance funds may be applied to the remaining balances of accounts from prior visits as well as to current accounts.

2. Eligibility for medical assistance will be limited to qualifying applicants that meet the income and sliding scale discount guidelines listed below:

FAMILY UNIT	MAXIMUM ANNUAL INCOME 200% FPL	FORGIVENESS PERCENTAGE	MAX. ANNUAL INCOME BETWEEN 200% & 300% FPL	FORGIVENESS PERCENTAGE
1	$25,520.00	100%	$38,280.04	Sliding Scale Formula:
2	$34,480.00	100%	$51,720.00	[Family Income] -
3	$43,440.00	100%	$65,160.00	[200% Guideline] =
4	$52,400.00	100%	$78,600.00	Over Income Amount
5	$61,360.00	100%	$92,040.00	
6	$70,320.00	100%	$105,480.00	[Over Income Amount] /
7	$79,280.00	100%	$118,920.00	[200% Guideline] = Result %
8	$88,240.00	100%	$132,360.00	
				[100 - (Result%)] =
				Percent Reduction in Charges

Example: A patient with a family unit size of 4 with actual income of $60,000.00

$60,000.00 - $52,400.00 = $7,600.00 $7,600.00/$52,400.00 = 15% 100% - 15% = 85.0%

* A "Family Unit" shall be defined as "any blood relatives living in the same household, any married couple living in the same household, or any non-related individuals living in the same household as a family unit."

* An "Economic Family Unit" shall be defined as all individuals living in the same household that have a legal financial responsibility with the guarantor of the account(s). An adjustment to the Economic Family Unit income will be made by increasing the total monthly income by the In-kind Support Maintenance Figure as determined by the federal government for each individual. The income adjustment will be made to account for shared living expenses. The income guidelines for an Economic Family Unit are the same as for a Family Unit.

* Examples of income include: pay from employment, interest, dividends, unemployment benefits, child support, alimony, Social Security benefits, Veteran's Administration benefits, benefits from all state and federal programs, and taxable tips.

3. Applicants must have resided in Sweetwater County at the time services were rendered.

4. Applicants may be requested to provide proof of application to Wyoming Medicaid.

5. Applicants must authorize Memorial Hospital of Sweetwater County to verify any and all information required for approval.

6. Applicants will receive a written determination of eligibility.

7. Any questions regarding the Medical Assistance Program may be directed to (307) 352-8548

Memorial Hospital
OF SWEETWATER COUNTY

MEDICAL ASSISTANCE APPLICATION
FOR DETERMINATION OF ELIGIBILITY

Guarantor Name: _____ Social Security No.: _____
Mailing Address: _____ (if applicable)
_____ Telephone No.: _____
Street Address: _____ City, State, Zip: _____ _____
Patient Name(s): _____ DOB: _____

Total Number of Persons in Your Household: _____

Name	Age	Relationship	
			-
			-
			-
			-

*(S=Spouse, C=Child, F=Friend, P=Parent)

INCOME: Please Total and Provide Documentation of Your Gross Household Income

Household Income Last Three Months: $ _____
Household Income Last Six Months: $ _____
Household Income Last Twelve Months: $ _____

EMPLOYMENT RECORD: Please List All Employment Held by All Members in Your Household for the Past Twelve Months.

Employer Name: _____ Telephone No.: _____
Employer Name: _____ Telephone No.: _____
Employer Name: _____ Telephone No.: _____

SAVINGS & INVESTMENTS:

Please List All Investments, Checking & Savings Account Locations & Numbers:

_____
_____
_____

HEALTH & ACCIDENT INSURANCE:

Does the Patient Have Health or Liability Insurance Coverage: ☐ Yes ☐ No Medicare or Medicaid: ☐ Yes ☐ No

If Yes, Please Complete the Insurance Information

Insurance Carrier Name: _____ Policy or Group No.: _____
Carrier Address: _____ City, State, Zip: _____
Subscriber Name: _____ Social Security No.: _____ (if applicable)

I give authorization to verify information with all financial institutions, creditors, and any other party which might be able to provide financial information about the details of this application. I authorize Memorial Hospital of Sweetwater County to verify all information and annual income amounts for all members of the family unit as listed above. I understand that the information I submit is subject to verification by Memorial Hospital of Sweetwater County and subject to review.

I certify that the above information is true, complete, and correct.

_____
Person(s) Making Request Date

Please call and make an appointment with our Patient Financial Navigators once you have everything together and ready to turn in.

BUSINESS OFFICE USE ONLY

This Document was Received on: _____ By (Name): _____

Title: _____

The following documents were provided to verify income, family composition, and Sweetwater County domicile:

☐ Paycheck Stubs ☐ Income Tax Form ☐ Bank Statement ☐ Other: _____

FUNDING RECOMMENDATION:

☐ Approved ☐ Denied Date: _____

Reason for Approval or Denial: _____

By (Name): _____ Title: _____

Authorized By: _____ Title: *Director - Patient Financial Svc.* Date: _____

Authorized By: _____ Title: _____ Date: _____

Letter Sent On: _____ By (Name): _____ Date: _____

Comments: _____