Open Door Health
7 Central St.
Providence, RI 02907
Phone: (401) 648-4700
Fax: (833) 905-2260

Financial Hardship Application Overview

Dear Open Door Health Client:

This Application provides you with an opportunity to let us know that paying the deductibles, co-insurance, or co-payment obligations under your insurance policy – or lack thereof - in connection with medical services provided at Open Door Health will result in an undue financial hardship. Please provide as much documentation as possible from the information requested below. This information will help us to determine the appropriate level of discount that we may offer you.

After completing the entire application (please print legibly), sign, date and attach income documentation for all persons in your household. Applicants must provide at least one of the following:

- Most recent W-2, 1099 or IRS tax return (1040EZ, etc.);
- Paystubs, for the past 90 days;
- Signed letter from your employer stating cash earnings ;
- Self-distribution statements for Business owners or a letter stating how much you usually earn in a month or year;
- Unemployment or disability check stubs for 90 days and/or letter detailing unemployment benefits from your state unemployment office;
- Military leave and earnings statement;
- Proof of all other income (SSI, SSDI, pensions, etc.);
- Application forms and/or statements for government and/or other sponsored assistance;
- Notarized letter stating you have no source of income, signed by you;
- Mock modified adjusted gross income worksheet IF none of the above are available to you (ask Open Door Health staff for assistance if this is required).
- **Bank statements do not qualify as proof of income.**

Failure to complete each applicable line item, to sign the application, attach the required documentation, or alter any of the provisions of the application by your third visit or within 60 days of your first visit will result in denial. If you're application is denied you will be responsible for the full fee of your visit. You may submit missing documents within a month of denial. You may reapply at any time.

Please return the Application (with attachments) to the address indicated on the bottom of the application. We look forward to assisting you.

NOTE: You must notify us promptly of any changes in your financial situation.

Financial Hardship Recertification
If you remain eligible, you may reapply 30 days prior and no later than 30 days after the expiration date on your approval letter. Failing to reapply or re-qualify will result in a denial of Financial Hardship benefits. All deductibles, co-insurance and co-payment amounts thereafter will be billed under Open Door Health's standard billing procedures.

Definitions
Household/Family: A household, for this application, means 2 or more people living together and sharing finances. This definition does not include roommates; splitting rent does not qualify as sharing finances.
Nominal Fee: This is a fee paid to the clinic for services rendered. This fee is not a co-payment but works like one.
Co-payment: This is a fee set by an insurance company to be paid to the clinic for an appointment or service. If you pay a co-payment, you don't have to pay a nominal fee. Some insurances do not allow co-payment discounts.
Self-pay: This happens when a person pays for healthcare themselves (insurance does not pay for services).

HHS Poverty Guidelines

HHS POVERTY GUIDELINES FOR 2020
The 2020 poverty guidelines are in effect as of January 15, 2020

Means-Tested Public Benefits
Federal Means-Tested Public Benefits: To date, federal agencies administering benefit programs have determined that federal means-tested public benefits include food stamps, Medicaid, Supplemental Security Income (SSI), Temporary Assistance for Needy Families (TANF), and the State Child Health Insurance Program (SCHIP).
State Means-Tested Public Benefits: Each state will determine which, if any, of its public benefits are means-tested. If a state determines that it has programs which meet this definition, it is encouraged to provide notice to the public on which programs are included. Check with the state public assistance office to determine which, state assistance programs are means-tested public benefits.
Programs Not Included: The following federal and state programs are **not included** as means-tested benefits:

- Emergency Medicaid;
- Short-term, non-cash emergency relief;
- Services provided under the National School Lunch and Child Nutrition Acts; Immunizations and testing and treatment for communicable diseases;
- Student assistance under the Higher Education Act and the Public Health Service Act; Certain forms of foster-care or adoption assistance under the Social Security Act; Head Start programs;
- Means-tested programs under the Elementary and Secondary Education Act; and Job Training Partnership Act programs.

Open Door Health Sliding Fee Discount Scale by Annual Income and Federal Poverty Level

Annual Income Thresholds by Sliding Fee Discount Class and Percent Federal Poverty Level			
INCOME (based on the 2020 Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia)			
% of Federal Poverty Level	ODH Financial Assistance and Sliding Fee Scale	ODH Ryan White Sliding Fee Scale	**Ryan White Eligible Patients Maximum Charge per Calendar Year**
0 – 100%	$0	$0	$0, No charges
101 – 125%	$10	$10	5% of gross annual income
126 - 150%	$15	$15	5% of gross annual income
151 - 175%	$20	$20	5% of gross annual income
176 - 200%	$25	$25	5% of gross annual income
200 – 300%	N/A	N/A	7% of gross annual income
300%+	N/A	N/A	10% of gross annual income

Financial Assistance and Sliding Fee Scale Application

Open Door Health (ODH) committed to providing quality medical to all persons without regard to their income or their ability to pay. Please complete the following information so ODH can determine your eligibility for discounted services. To remain eligible for discounted care, you will be required to recertify your financial assistance application every six months and provide updated proof of income.

Legal First Name: _____ **Chosen Name:** _____ **Legal Last Name:** _____
Date of Birth: _____ **Social Security or Tax ID Number** (*optional*)**:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Primary Phone Number: _____ **Secondary Phone Number:** _____
Do you have commercial health insurance, Medicaid, or Medicare? ▫ Yes ▫ No ▫ Not Sure
What is your annual deductible? _____ ▫ I don't know

HOUSEHOLD
A "household" includes legal children, a civil union or domestic partner or married spouse, legal dependents, and unrelated family members living in the same residence who are supported by or who are a supporting member of the family. Please list the name/s of individuals in your household and their relation to you. Use the back of this form for additional space.

Names of Household Members	**Relation to You**
TOTAL Number of People in the Household (including yourself):	

ANNUAL HOUSEHOLD INCOME
To qualify, you will need to submit proof of your household's annual gross (before-tax) income. Annual gross income includes salary, unemployment benefits, disability or social security benefits, investment income or other sources of income that support your household. Please indicate income you and other members of your household received from each source.

Source of Income	**Self**	**Spouse**	**Other**	**Total**
Gross Wages, Salaries, Tips etc				
Social Security (SSI/SSDI)				
Unemployment Benefits				
Investment Income				
Other				
Total Income				

THIS FORM IS DOUBLE SIDED

Attestation of Financial Hardship

Please read and sign:

I have reviewed this form and certify that all the information provided is correct and complete to the best of my knowledge. I ackowlegde that the above information has been provided for the purpose of evaluating whether I qulity for the Financial Hardship program. I understand that I am personally responsible for all health center charges until such time as I have supplied the necessary documentation to support my application. I understand that I will be charge the **full fee of my visit** if I do not bring in documentation of income by my **third visit or within 60 days of my first visit**, whichever comes first. I understand that I am required to notify Open Door Health if my income level changes or if I become insured. If there are changes, I will be re-assessed for the sliding fee scale. I understand that in the absence of a material change in income, I must reapply and requalify for the sliding fee scale no less frequently than every six (6) months unless advised otherwise.

Print Name: _____ Date: _____

Patient Signature: _____

Guardian Signature (if applicable): _____

PLEASE RETURN THIS APPLICATION TO:
Open Door Health
ATTN: Financial Services Team
7 Central Street
Providence, RI 02907

To speak with someone in Open Door Health Health's Financial Hardship Office, please call: 401-648-4700

For Internal Use Only

Number in household: _____ **Annualized Income: _____**

ODH SFS Program Eligibility

- ☐ 0-100% FPL ($0)
- ☐ 101-125% FPL ($10)
- ☐ 126-150% FPL ($15)
- ☐ 151-175% FPL ($20)
- ☐ 176-200% FPL ($25)
- ☐ >200% (Full fee, not eligible)

Reviewed By: _____

Effective Date: _____

Termination Date: _____