Financial Hardship Policy

Purpose:

Steinberg Diagnostic Medical Imaging hereinafter referred to as “SDMI” has established this policy in an order to maintain consistency in assisting indigent patients who request a reduction or waiver of certain radiology charges and/or copayment amounts.

This policy outlines SDMI’s policies and procedures in relationship to the application and approval process for indigent patients. SDMI will take into account the overall financial circumstances of the applicant and apply this policy consistently.

If approved, SDMI may elect to reduce or waive certain amounts which are due from non-subscribers who can successfully demonstrate that paying radiology fees would cause significant financial hardship.

Financial Hardship Criteria:

SDMI will take into account a range of factors when deciding whether the full payment of the radiology charges will cause the applicant financial hardship. In making the decision whether to waive the fee, SDMI will compare the amount earned, living expenses, assets and debts. Written verification, when available, may be required to substantiate and verify information contained in the financial hardship application.

SDMI uses a combination of the current year’s federal poverty guidelines to help in determining if an applicant qualifies for a financial hardship waiver. (Attachment A)

In applying these guidelines, SDMI will also consider and take into account any other income and expenses including money earned in the entire household. Income and employment status verification may be required; including tax returns; check stubs, etc.

1. Whether payment of the radiology charges will affect the applicant’s ability to pay for the following living expenses:
   • food and clothes;
   • rent or mortgage payments;
   • any other basic needs; or
   • any special needs (for a serious illness or disability)

2. Whether the applicant owns any assets, such as a car or house. Assets also include:
   • investments;
   • money in the bank;
   • cash on hand for short term expenses; and
   • money designated for special needs.

3. Whether the applicant has any debts.
Steinberg Diagnostic Medical Imaging

Application Process for Financial Hardship

An application for a financial hardship waiver of radiology charges and fees must be made in accordance with Steinberg Diagnostic Medical Imaging, hereinafter referred to as “SDMI”, policy entitled “Financial Hardship Policy”.

Applicants can request and complete a Financial Hardship Application Form. The form can be obtained by calling (702) 732-6000 option 5, by visiting any of the SMDI facilities during normal business hours or going to the SDMI website www.sdmi-lv.com. Forms can also be requested from the SDMI Business office through submission of a written request to PO Box 36900, Las Vegas, NV  89133. Applicants are required to return the completed forms and submit all required documentation to SDMI.

Required Information:

SDMI requires independent information to support claims of financial hardship including verification of expenses and income. The information submitted will be treated confidentially and will only be reviewed by SDMI administrative staff involved in processing requests for waiver of radiology charges.

Time Frame:

After an application and verification information is received, SDMI will consider the overall financial situation of the applicant and then render a decision. SDMI has designated the authority to grant or reject requests for financial hardship waivers to the Billing / Collection Managers. All decisions will be made within 10 working days from the time that SDMI receives and reviews all required information.

Applicants will receive a notification letter outlining whether or not the application has been approved or rejected. If your request for waiver of the charges is rejected, SDMI will provide the applicant with a written summary and explanation of its decision. If the applicant’s situation changes the patient or their designee may reapply.

SDMI administrative staff will maintain all documentation related to the financial hardship waiver process. This documentation will include all supporting documentation including the waiver request and all documents provided in support of the request.

Verification of ongoing qualification for financial hardship will be conducted at any time the applicant requests a waiver of radiology charges or other applicable copayment amounts.

Income shall be annualized from the date of request based on documentation provided, and upon verbal information provided by the patient or their designee. The annualization process will also take into consideration seasonal employment and temporary increases and/or decreases to income.

PLEASE COMPLETE THE ATTACHED APPLICATION AND FINANCIAL STATEMENT. YOUR REQUEST CAN NOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL STATEMENT IS FULLY COMPLETED AND SIGNED!
2014 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

<table>
<thead>
<tr>
<th>Persons in Family / Household</th>
<th>Poverty Guideline</th>
<th>200% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,670</td>
<td>$23,340</td>
</tr>
<tr>
<td>2</td>
<td>$15,730</td>
<td>$31,460</td>
</tr>
<tr>
<td>3</td>
<td>$19,790</td>
<td>$39,580</td>
</tr>
<tr>
<td>4</td>
<td>$23,850</td>
<td>$47,700</td>
</tr>
<tr>
<td>5</td>
<td>$27,910</td>
<td>$55,820</td>
</tr>
<tr>
<td>6</td>
<td>$31,970</td>
<td>$63,940</td>
</tr>
<tr>
<td>7</td>
<td>$36,030</td>
<td>$72,060</td>
</tr>
<tr>
<td>8</td>
<td>$40,090</td>
<td>$80,180</td>
</tr>
</tbody>
</table>

For families / households with more than 8 persons, add $4,060 for each additional person.

The figures are the 2014 HHS poverty guidelines as of January 22, 2014.  
(Source: http://aspe.hhs.gov/poverty/14poverty.cfm)
Steinberg Diagnostic Medical Imaging

Financial Hardship Application

Please complete the application and attached financial statement. Please return all forms and required documentation (in person, by fax or by mail) to Steinberg Diagnostic Medical Imaging, PO Box 36900, Las Vegas, NV 89133 Fax: 702-515-8491

All information relating to financial hardship requests will be kept confidential.

Patient Name: _________________________________________________________

Address 1: ____________________________________________________________________________

Address 2: ____________________________________________________________________________

Telephone #: (______)________-_________

DOB: ____/____/_______      SS #: ________-_________-____________

Date of Service: ____/____/_______    Alternate Date of Service: ____/____/_______

Name of Person completing this Application (if different than patient listed above)

_______________________________________________________________________________

_______________________________________________________________________________

Telephone #: (_____)________-_________

Relationship to Patient: _____________________________________________________________

NUMBER OF FAMILY MEMBERS (LIVING IN HOUSEHOLD):__________

Do you have Health Insurance, Medicare or Medicaid?   ☐ Yes ☐ No

If yes, what insurance do you have?  ____________________________________________

If no, please explain since the Patient Protection & Affordable Care Act requires Americans to obtain health insurance by January 1, 2014 or a tax penalty. ________________________________

☐ Check here if UNEMPLOYED.  HOW LONG? ______________________

☐ Check here if you are on Social Security or Disability.  HOW LONG? ________________

Did you file a Federal Income Tax Return last year? ☐ Yes ☐ No

Will you file a Federal Income Tax Return this year? ☐ Yes ☐ No

PLEASE LIST ALL CURRENT EMPLOYERS:

Employer 1: __________________________________________________________________

Address: _______________________________________________________________________

Contact Person: ___________________________ Telephone: (_____)________-_________

Employer 2: __________________________________________________________________

Address: _______________________________________________________________________ 

Contact Person: ___________________________ Telephone: (_____)________-_________
Please provide documentation of proof of income. **Appropriate documentation of financial hardship** would be the following:

1) Documented proof that patient is at or below 200% of the current federal poverty guidelines (see attachment A for current federal HHS guidelines). Documents include:

- Income tax return (most recent signed 1040)
- W-2 withholding statements or unemployment check stubs for the past 90 days
- Pay check stubs for the past 60 days for all persons employed in the home
- Proof of all other income received in the past 90 days
- Application Forms from Medicaid or other State-funded medical assistance program
- Forms from employers or welfare agencies.

2) Patient has other circumstances that indicate financial hardship. These can be situations such as:

- Proof of all outstanding debts or bills (copies of bills, statements; late notices, etc.)
- Proof of bankruptcy settlement (if applicable)
- Catastrophic situations (death or disability in family, divorce) or other documentation which demonstrates the patient would be unable to pay medical bills and still be able to pay for other basic necessary expenses.

3) Please describe patient indigent circumstances:

____________________________________________________________________________
____________________________________________________________________________

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**MONTHLY FAMILY INCOME & SOURCE**

<table>
<thead>
<tr>
<th></th>
<th>Patient</th>
<th>Spouse</th>
<th>Dependents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly Salary (Gross)</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
</tr>
<tr>
<td>Public Assistance Benefits</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
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<tr>
<td>Unemployment Benefits</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
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<tr>
<td>Social Security Benefits</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
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<tr>
<td>Workman’s Compensation</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
</tr>
<tr>
<td>Child Support</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
</tr>
<tr>
<td>Other (Alimony, Etc.)</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
</tr>
<tr>
<td>Subtotal:</td>
<td>$_______</td>
<td>$_______</td>
<td>$_________</td>
</tr>
<tr>
<td>TOTAL FAMILY INCOME</td>
<td>$___________________</td>
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<td></td>
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</tbody>
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*I HEREBY ACKNOWLEDGE THAT THE INFORMATION GIVEN HEREIN IS TRUE AND CORRECT. I AUTHORIZE STEINBERG DIAGNOSTIC MEDICAL IMAGING TO VERIFY ANY INFORMATION CONTAINED IN THIS DOCUMENT FOR THE SOLE PURPOSE OF ASSESSING FINANCIAL NEED.*

________________________________________________________  _____/_____/_________
Signature of Person Making Request               Date

_________________________________________________________
Printed Name of Person Making Request