Steinberg Diagnostic Medical Imaging Centers
"Where Imaging Revolves Around You" SM

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P.O. Box 36900, Las Vegas, NV 89133
(702) 732-6000

# 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 will use a combination of the current year's federal poverty guideline and a medical credit check to determine if an applicant qualifies for a financial hardship waiver. A medical credit check does not affect the applicant's credit score.

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.
4. Patient must reside within 150 miles of a SDMI facility

# 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 the Billing Department at (702) 732-6000 option 5, by visiting any of the SDMI 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 Financial Hardship Division of SDMI. **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 the applicant's situation changes the patient or their designee may reapply.

All documentation related to the financial hardship waiver process will be maintained in a secure environment. 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!***

# 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: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _(_____)_____-_____ DOB: _____/_____/_____

SS #: _____-_____-_____ 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 <u>including</u> yourself**):_____

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

If yes, what insurance do you have? _____

If no, please explain why. _____

_____

☐ Check here if you are Unemployed. HOW LONG? _____

Are you collecting unemployment benefits? ☐ Yes ☐ No

☐ Check here if you are on Social Security. HOW LONG? _____

☐ Check here if you are on Disability. HOW LONG? _____

☐ Check here if you are getting food stamps or any monetary assistance. What type?

_____

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

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

**PLEASE LIST ALL CURRENT EMPLOYERS**:

Employer 1: _____

Employer 2: _____

## *Financial Hardship Application (continued)*

**Please provide documentation of proof of income**. Appropriate documentation of financial hardship would be the following:

1) Documents should include:

- ☐ **Income tax return (copy of the most recently signed 1040 Tax Return)**
- ☐ **Pay check stubs for the past 60 days for all persons employed in the home**
- ☐ **Current year Social Security or Disability letter with benefit amounts**
- ☐ **Unemployment check stubs for the past 90 days**
- ☐ **Proof of all other income received in the past 90 days**
- ☐ Application Forms from Medicaid or other State-funded medical assistance program

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: _____
_____

| MONTHLY HOUSEHOLD INCOME & SOURCE | | | |
|---|---|---|---|
| | Patient | Spouse/Parents | Dependents |
| Monthly Salary (**Gross**) | $_____ | $_____ | $_____ |
| Public Assistance Benefits | $_____ | $_____ | $_____ |
| Unemployment Benefits | $_____ | $_____ | $_____ |
| Disability Benefits | $_____ | $_____ | $_____ |
| Social Security Benefits | $_____ | $_____ | $_____ |
| Workman's Compensation | $_____ | $_____ | $_____ |
| Child Support | $_____ | $_____ | $_____ |
| Food Stamps | $_____ | $_____ | $_____ |
| Other (Alimony, Etc.) | $_____ | $_____ | $_____ |
| Subtotal: | $_____ | $_____ | $_____ |
| TOTAL HOUSEHOLD INCOME | $_____ | | |

*I hereby acknowledge that the information given herein is true and correct. I authorize Steinberg Diagnostic Medical Imaging to validate the information contained in this document by a Medical Credit Check for the sole purpose of assessing financial need.*

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

_____
Printed Name of Person Making Request

**Note: If all documentation REQUESTED is not received, including the most current complete signed INCOME TAX RETURN and PROOF OF INCOME for every family member in the household, the application will be DENIED.**