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 Nevada in either Clark, Lincoln or Nye counties

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 will be directed to the SDMI Patient Portal at **sdmi-lv.patientsimple.com/** . The on-line form must be filled out by the patient, guarantor or their legal representative. For applicants who do not have access to a computer a manual process will be available.

Required Information:

The applicant will be required to provide the number of family members in the household and what the combined income is for the household. The applicants zip code will also be required. A medical credit check will be used to verify the information provided.

Time Frame:

After an application is submitted, immediate results will be provided. The applicant will receive a notification letter outlining whether or not the application has been approved or denied.

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.

Manual Application Process for Financial Hardship:

Applicants can request and complete a **Financial Hardship Application Form.** The form can be obtained by calling the Billing Department at (702) 732-6000, requested from the SDMI Business office through submission of a written request to PO Box 36900, Las Vegas, NV 89133 or through SDMI's website at **sdmi-lv.com**.

Time Frame:

After an application is received, SDMI will use Experian Health to run a medical credit check to verify the information provided. 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.

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

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.

PLEASE COMPLETE THE ATTACHED APPLICATION. YOUR REQUEST CAN NOT BE PROCESSED UNLESS THE APPLICATION IS FULLY COMPLETED AND SIGNED!

FINANCIAL HARDSHIP POLICY

Please complete the application and return (in person, by fax or by mail) to Steinberg Diagnostic Medical Imaging, PO Box 36900, Las Vegas, NV 89133 Fax: 702-515-8491 Attn: Financial Hardship Division.

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**):________________

MONTHLY HOUSEHOLD INCOME & SOURCE

	Patient	Spouse/Parents	Dependents
Monthly Salary (**<u>Gross</u>**)	$____________	$____________	$____________
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