aspenti HEALTH

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2018 Aspenti Health "Financial Affordability in Recovery" Form

Purpose:

Aspenti Health ™, DBA to BLA Partners, LLC and BLA Massachusetts, LLC, together herein referred to as "Aspenti", understand that sometimes the cost of treatment creates a financial burden for patients. For this reason, we created the *Financial Affordability in Recovery* program, also referred to as "FAIR". The establishment of this policy maintains consistency in supporting patients eligible for financial support and helps in the successful recovery of patients completing their treatment plans. BLA will review the financial circumstances of each applicant and apply this policy consistently.

Patients who qualify for financial support will receive reductions up to 100%.

Financial Support Criteria:

Aspenti uses the current year's federal poverty guidelines to help determine if an applicant qualifies for a financial support (Attachment A).

Several forms or proof of income will be allowed when determining whether a patient meets program eligibility requirements. Written verification, when available, may be required to substantiate and verify information contained in the FAIR application. In applying these guidelines, BLA may review income and employment status verification, including tax returns, check stubs, etc.

Application Process for Financial Support:

Financial support of laboratory charges must be made in accordance with Aspenti Health's policy entitled "**Financial Affordability in Recovery Policy".**

Applicants can request and complete a **FAIR Form.** The form can be obtained by calling 1-844-850-7180, emailing us directly at FAIR@aspenti.com, visiting any of the Aspenti Health facilities during normal business hours or going to the Aspenti website www.Aspenti.com. Forms can also be requested from the Aspenti business office through submission of a written request to Aspenti Health, 30 Community Drive, Suite 2, South Burlington, VT 05403 Attn: Billing Dept. Applicants are required to return the completed forms and submit all required documentation to BLA.

Required Information:

Aspenti requires personal financial information to support claims of financial hardship. The information submitted will be treated confidentially and will only be reviewed by the Aspenti administrative staff involved in processing requests for waiver of laboratory charges.

Time Frame:

After an application and verification information is received, Aspenti Health will consider the overall financial situation of the applicant and then render a decision. Aspenti has designated the authority to grant or reject requests for financial

support to the Billing Supervisor. **All decisions will be made within 10 business days from the time that Aspenti receives all required information**.

Applicants will receive a notification letter outlining whether the application has been approved or rejected. If the request for waiver of the charges is rejected, Aspenti 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.

Aspenti's administrative staff will maintain all documentation related to the FAIR program. This includes the FAIR application form and all documents provided in support of the request.

If an applicant is deemed to be eligible to receive financial support, the eligibility will be in effect for **one year** from the effective date. Verification of ongoing qualification for financial support may be conducted at any time.

Patients have up to 90 days from date of service to submit their application to apply their eligible financial support to the services performed.

Income shall be annualized from the date of request based on documentation provided by the patient or their designee.

PLEASE COMPLETE THE ATTACHED FINANCIAL AFFORDABILITY IN RECOVERY APPLICATION FORM. YOUR REQUEST CAN NOT BE PROCESSED UNLESS THE APPLICATION AND FINANCIAL DATA IS FULLY COMPLETED AND SIGNED!

Financial Affordability - Attachment A

2017 POVERTY GUIDELINE QUALIFICATION
Aspenti Health provides financial support to patients with an annual household income at or below the amounts reflected here:

Persons in Family/Household	**400% of Federal Poverty Guidelines** (BLA's maximum household income to qualify for Financial Support)
1 Person	$48,240
2 Persons	64,960
3 Persons	81,680
4 Persons	98,400
5 Persons	115,120
6 Persons	131,840
7 Persons	148,560
8 Persons	165,280
For families/households with more than 8 persons	Add $16,720 for each additional person

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Financial Affordability in Recovery Application Form

Patient full legal name:		Date of birth:
SSN:	Phone:	Email address:
Current address:		
City:	State:	ZIP Code:

Does the patient have medical coverage? YES NO (please circle one)	IF "YES" please list responsible party information (Please include a copy of insurance card):
Insurance Company Name:	
Address:	
Phone number:	Policy holder name and ID:

Financial	Total Gross Yearly Income (before taxes) $ ___________________________________ (Include pay stub, W-2, unemployment or disability statement, or other verification of income)
	Household Size: _________________ (Number of people who contribute to or are dependent on your household income) Your application may be subject to audit or request for additional documentation

☐ 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? __________________________

PLEASE LIST ALL CURRENT EMPLOYERS

Employer 1: ____

Employer 2: ____

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Financial Affordability in Recovery Application Form (Continued)

Please provide proof of income documentation. Appropriate documentation for financial support would be the following:

1) At least **ONE** documented proof that patient is at or below 400% of the current federal poverty guidelines. Patient must submit any of the following that apply:

- ○ **Income tax return (copy of the most recently signed 1040 Tax Return)**
- ○ **Pay check stubs for the past 90 days for all persons employed in the home**
- ○ **Current year Social Security or Disability letter with benefit amounts**
- ○ **Proof of all other income received in the past 90 days, including unemployment benefits**
- ○ **Letter from Medicaid or other state-funded medical assistance program**

I hereby acknowledge that the above information is true and correct according to the best of my knowledge and belief. I authorize Aspenti Health to verify the above information for the sole purpose of assessing financial need. I understand that if I do not qualify, I will be notified and Aspenti Health will bill me directly. I have agreed to notify Aspenti Health if my financial condition changes or improves.

Patient Name (Print) ____ Date: ___________________________________

Patient Signature: ____ Date: ___________________________________

Responsible Party Signature: ______________________________________ Date: ___________________________________

Mail completed application to:

Aspenti Health
30 Community Drive, Suite 2
South Burlington, VT 05403.

For Internal use only:

Accession numbers (attach list)		Amount $	Approved	Denied
Dates of service coverage begins:				
Dates Financial Aid Expires:				
Date Received:	Date Approved/Denied	PSC Rep <$1K: ____________ Supervisor Signature >$1K & <$5K: ____________ CFO Signature >$5K: ____________		