2021 Aspenti Health Financial Affordability in Recovery (FAIR) Form

PURPOSE:

BLA Partners, LLC dba Aspenti Health, herein referred to as "Aspenti", understands 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". This program provides consistency in supporting patients eligible for financial support and helps in the successful recovery of patients completing their treatment plans. Aspenti will review the financial circumstances of each applicant and apply the criteria 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 financial support (Attachment A).

Several forms or proof of income are 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, Aspenti may review income and employment status verification, including tax returns, check stubs, etc.

APPLICATION PROCESS FOR FINANCIAL SUPPORT:

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

Applicants are required to return completed FAIR form and submit all required documentation to Aspenti. The form is located on the Aspenti website **www.aspenti.com** and at all our Aspenti Health locations. In addition, forms can be obtained by calling **1-844-850-7180**, emailing **FAIR@aspenti.com**, or mailing a written request to **Aspenti Health, 530 Community Drive, Suite 2, South Burlington, VT 05403 Attn: Brian Bouchard.**

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 support of laboratory charges.

TIME FRAME:

After application and verification information is received, Aspenti Health will consider the overall financial situation of the applicant to render a decision. Aspenti has designated the authority to approve or reject requests for financial support to the Billing Manager. **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 securely 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 eligible to receive financial support, the eligibility includes dates of service 90 days prior to the effective date and remains in effect for **one year**. The effective date is the date the application is signed. 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 FAIR FORM. YOUR REQUEST CAN NOT BE PROCESSED UNTIL THE APPLICATION AND FINANCIAL DATA IS COMPLETED FULLY AND SIGNED.

FINANCIAL AFFORDABILITY—ATTACHMENT A

2021 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 (Aspenti's maximum household income to qualify for Financial Support)
1 Person	$51,040
2 Persons	$68,960
3 Persons	$86,880
4 Persons	$104,800
5 Persons	$122,720
6 Persons	$140,640
7 Persons	$158,560
8 Persons	$176,480
9 Persons	$194,400
10 Persons	$212,304

FAIR Application Form

Patient Information

Patient Full Legal Name:		Date of Birth:
SSN:	Phone:	Email Address:
Current Address:		
City:	State:	Zip Code:

Insurance information

Does the patient have medical coverage? ☐ Yes ☐ No	If yes, complete below (please include a copy of insurance card):
Insurance Company Name:	Insurance ID:
Address:	
Phone Number:	Subscriber name and date of birth:

Financial Information (all values should reflect yearly amounts for the entire household)

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: _____

FAIR Application Form (continued)

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

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

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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 in any manner.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Guarantor Name: _____

Guarantor Signature: _____ Date: _____

Mail completed application to:

Aspenti Health
530 Community Drive, Suite 2
South Burlington, VT 05403
ATTN: Brian Bouchard

For internal use only:			
Current Balance:	Effective Date:	Expiration Date:	Approval Percentage:
Date Received:	Date Reviewed:	Signature and Date: Patient Service Center <$1K: _____ Revenue Integrity and Billing >$1K & <$5K: _____ CFO Signature >$5K: _____	