William Newton Hospital

Financial Assistance Summary

William Newton Hospital, its employed physicians, outpatient provider-based clinics, rural health clinics and ancillary services (hereinafter referred to as WNH) have a long tradition of serving those who are economically disadvantaged and all who require healthcare services. WNH is committed to providing Financial Assistance for the healthcare needs of individuals who are uninsured, underinsured, ineligible for government programs or otherwise unable to pay for medically necessary care based on their financial situation.

WNH provides care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay. When appropriate a transfer to another facility better equipped to administer the treatment will be arranged even if the patient cannot pay or does not have medical insurance. The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay within the meaning of the Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd).

In order to promote the health and well-being of the communities served by WNH, individuals with limited financial resources shall be eligible for free or discounted health care services based on established criteria. Eligibility criteria will be based upon 120% to 200% Federal Poverty guidelines www.aspe.hhs.gov/poverty and will be revised annually in conjunction with the published updates by the United States Department of Health and Human Services.

Financial Assistance Application Process

Appropriate signage is visible in WNH facilities, specifically at patient intake areas, to increase awareness of the Financial Assistance Program. A Financial Assistance Packet will be available which includes the Financial Assistance Application, Financial Assistance Summary and Payment Policy. This information is also listed on the WNH website www.wnhcares.org and applications will be mailed upon request. Patients are responsible for completing the Financial Assistance Application and for providing the required documentation, in order to determine eligibility for Financial Assistance.

Eligibility

To be eligible for a 100% reduction from the patient portion of billed charges, the Family/Household Income must be at or below 120% of the current Federal Poverty Guidelines www.aspe.hhs.gov/poverty. If you fall between 120% to 200% of the Federal Poverty Guidelines an adjustment based on sliding fee discount will be applied decreasing your gross charges. If a determination leaves the patient with a remaining self-pay balance, payment terms will be established from the payment policy.

- Uninsured patient account can be eligible for (1) Amount Generally Billed adjustment and (2) Financial Assistance adjustment.

- Insurance patient account can be eligible for (1) Insurance Contractual adjustment.
  (2) Financial Assistance adjustment on balance after insurance.

Payment Policy

Equal monthly payments on account balances are expected within the following time frames:

$1.00 to $300	60 days
$301 to $600	3 months
$601 to $1,500	6 months
$1,501 to $4,000	9 months
$4,001 up	12 months

We accept cash, check, money order, Visa, MasterCard, or Discover.

Financial Assistance Application

Please fill out the application in its entirety and supply the required documents needed to process it correctly. Failure to submit the requested information may result in the denial of your application because your financial eligibility could not be determined. If there is any reason the listed documentation cannot be provided, please include a written explanation stating the reason. Allow the necessary time to verify the information that you have provided. Please return the application within 10 days of receiving it. You will receive a written notification of approval or denial, generally within 30-90 days.

Patient's Legal Name	
If under 18 Guarantor Name	
Patient Date of Birth	
Date of Service(s)	
Account Number(s)	
Mailing Address	
Phone Number	

List members of the Family/Household Unit: (defined as applicant, spouse/significant other, and all legal dependents according to IRS definition)

Name	Relationship	Date of Birth	Currently Employed (Yes/No)

A. Are any members of your family unable to work due to age, illness or injury? ☐ Yes ☐ No

B. If family member is over 18 and not employed, please provide date last worked ___/____/____ and the name of the previous employer: _____

C. Are there other additional medical or financial problems within the household? ☐ Yes ☐ No

D. Has the patient/guarantor filed for bankruptcy within the last 12 months? ☐ Yes ☐ No

MONTHLY INCOME REPORT: **Provide all income verification listed below that applies to the Family/Household Unit (applicant/patient, spouse/significant other, and legal dependents). Include with your application proof of all income for previous two (2) months**: i.e., pay stubs, social security, disability, pension, unemployment, alimony, child support, etc.

Source	Self	Spouse/Significant Other	Dependent	Total
Gross wages, salaries, tips, etc.				
Income from business and self-employment				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension, or retirement income				
Interest; dividends; royalties; income from rental properties, estates, and trusts; alimony; child support; assistance from outside the household; and other miscellaneous sources				
TOTAL INCOME				

The following requested documents are REQUIRED to be turned in with your application:

PLEASE NOTE: WE ONLY ACCEPT COPIES OF DOCUMENTS
DO NOT SEND ORIGINALS WE UNABLE TO RETURN DOCUMENTS OR MAKE COPIES
PLEASE UTILIZE THE CHECKLIST BELOW TO ENSURE ALL REQUESTED ITEMS ARE ACCOUNTED FOR

- ☐ Income tax returns for most recent year (**MUST be a full copy of all pages of the 1040; we cannot accept summaries. MUST also include all supporting schedules and attachments**) - (if none, please explain:) _____
- ☐ Last **2 months** of income documentation (including regular payroll, retirement, pension, commissions, bonuses, farm, sales, or any other income you receive)
- ☐ Last **2 months** of bank statements
- ☐ Official Unemployment letter/statement (if applicable)
- ☐ Official Social Security and/or Social Security Disability Benefit **award letter** for the **CURRENT YEAR** (if applicable).
- ☐ Documentation of Child Support received (if applicable). You can obtain this information from the KPC website. Please provide us with a printout.
- ☐ Monthly Income Report (*above*) must be completed in its entirety – Please write N/A in boxes if items are non-applicable
- ☐ Application completed in its entirety and ***signed by all responsible parties. SPOUSE MUST SIGN ALSO, IF YOU ARE MARRIED.***

Please return the application within 10 days of receiving it. A written decision regarding approval or denial will be provided, generally within 30-90 days of receipt of a completed application. WNH financial assistance does not apply to bills received from the doctor, radiologist, anesthesia, or ambulance. You must contact these providers directly. WNH accounts prior to the application period are still your responsibility.

I understand that the information which I submit is subject to verification by WNH and subject to review by others required. I certify the information in this financial application is true and correct. I also understand that if any portion of the information I have provided is determined to be falsified, I will be responsible for all medical expenses incurred at WNH. I agree to promptly notify WNH of any changes to my family/household status including family/household size, income, or insurance coverage that could change my financial status and eligibility for Financial Assistance. I understand this application is good for 6 months. **I understand that WNH cannot share confidential information without my prior approval.**

All responsible parties for WNH charges are required to sign application below.

Signature: _____ Date: _____

Signature of Spouse: _____ Date: _____
(If married, spouse signature required)

Do you have questions? Please call 620-222-6240
Where do I return the application? William Newton Hospital
Attn: Credit/Collections Department
1300 E. 5th Avenue
Winfield, KS 67156

William Newton Hospital

The following professional charges are not covered by William Newton's Financial Assistance Policy. Inquiries should be made by the patient with these organizations directly as they may have their own financial assistance policies.

- Cancer Center of Kansas
- Community Health Center of Cowley County
- Family Care Center
- Infectious Disease Consultants
- Kansas Pathology Consultants
- KC Pathology, PA
- Mid Kansas ENT
- Nephrology Services
- Pain Management Associates
- Pulmonology Services
- Rheumatology Services
- Urgent Care of Cowley County
- Wichita Radiology Group
- Wichita Urology Group

For more information contact our Credit/Collections Department at 620-222-6240.

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The following professional and technical charges are covered by William Newton's Financial Assistance Policy.

- Direct billing from William Newton Hospital
- Health Professionals of Winfield
- Sunflower OB/GYN at WNH
- William Newton Cardiology
- William Newton Foot & Ankle
- William Newton Hillside Family Medicine
- William Newton Orthopedics
- William Newton Pediatrics
- William Newton Rural Clinics
    - Cedar Vale Rural Health Clinic
    - Dexter Community Rural Health Clinic
    - Moline Community Rural Health Clinic
    - Tallgrass Rural Health Clinic
- William Newton Surgery and Services

For more information contact our Credit/Collections Department at 620-222-6240.