FINANCIAL ASSISTANCE PROGRAM

The Pioneers Medical Center/Meeker Family Health Center Financial Assistance Program provides discounted health care services to low income individuals based upon a sliding fee scale.

Eligibility Requirements:

* ***Established resident*** of Rio Blanco County. A resident of Rio Blanco County is a person who currently lives in the county and intends to remain in the county.
* Coverage is provided for all family members living at home including students up to the age of 21. Children for whom child support is provided will be counted as a household member.
* Must meet income guidelines.
* May have health insurance.
* Ineligible for Medicaid or CHP.
* Eligibility will be reassessed every 6 months.

Application Process:

* Applicant ***must make an appointment*** with a staff member to determine eligibility. Please call 970-878-5047.

Cost:

* Applicants will be given a rating based on their total household income; copayments will be determined as a result of the rating. Applicants are eligible to receive care at the time of the application.

Required Documentation:

Applicants are **required** to provide the following documents:

*** At least **two** of the three
  - ****State of Colorado driver's license, Colorado state ID card or picture ID**
  - ** **Receipts for mortgage or rent payments for 6 months. Receipts must have local address indicated. If renting, please also indicate name, address, and phone number of landlord.**
  - ****Colorado title and registration for motor vehicle (must be obtained within 30 days from establishing Colorado residency)**
* **Medicaid denial**
* **Copy of last 3 months' paycheck stubs, previous year's tax return, or 1099 form. If self employed, must provide a copy of the Schedule C.**
* Documentation of other income sources, including self-employment, unearned income; i.e. unemployment or worker's compensation, Social Security payments, payments from retirement plans and pensions, commissions, tips, alimony, trust accounts, income from rental properties, interest income from savings accounts, stocks, bonds, etc.
* **Documentation of checking and savings account information**

The following may be required:

* If not working, a copy of the previous 3 months' household bills
* A copy of health insurance card

Client Copayments:

* A client is responsible for paying a portion of his or her medical bills. This is the "client copayment". **Copays are due prior to receiving the service. Non-emergent services may be rescheduled if the patient is unable to provide the copay.**
* A client's copayment will be based upon the Colorado Indigent Care Program's "Ability to Pay" Scale.
* Outstanding balances will be adjusted for services provided 30 days prior to the signed application and all copays will be due at the time of the completion and approval of the application.
* Copay balances not paid within 120 days will be transferred to A-1 Collection Agency. Consistent failure to pay co-pays may result in the patient relationship being terminated.

The following procedures are **excluded** from the Financial Assistance Program:

1. Elective surgeries which are not medically necessary.
2. Nursing home care
3. Cosmetic surgery

CLIENT COPAYMENT TABLE
(Effective 3/15/13)

Definitions:
1. Hospital inpatient, ambulatory surgery, and observation service copays are for facility (non-physician) services. Elective ambulatory surgeries are not eligible for the Financial Assistance Program.
2. Physician copays for Inpatient, Surgery, and Observation status are related to services provided by the physician in the hospital setting.
3. Physician and Outpatient Clinic copays are for charges by the physician for primary and preventive medical care and ER visits. Outpatient clinic copays include physical, occupational, and speech therapy, and services provided in the hospital outpatient treatment room.
4. Hospital Emergency Room are charges related to non-physician (facility) charges only
5. Copays for MRIs, CT scans, labs, xrays, and cardiopulmonary services performed in the ER include the ER copays.
6. Xray copays do not include MRI and CT scans.

Rating	**Percent of Poverty Level**	**Hospital Inpatient , Ambulatory (Day) Surgery, Observation** ***(Entire Stay)*** **(Facility Charges) Copayment (1)**	**Inpatient, Surgery, Observation Physician** ***(Entire Stay)*** **(Dr. Charges) Copayment (2)**	**Physician (inc ER) and Outpatient Clinic (PT, OT, ST, Treatment Room,)** ***(per visit)*** **Copayment (3)**	**Hospital Emergency Room** ***(per visit)*** **(Facility Charges) Copayment (4)**	**MRI, CT** ***(per visit)*** **Copay (5)**	**Lab/Xray/ Cardio Respiratory** ***(per visit)*** **Copay (6)**
N	40%	$15	$7	$7	$15	$30	$7
A	62%	$65	$35	$15	$25	$90	$10
B	81%	$105	$55	$15	$25	$130	$10
C	100%	$155	$80	$20	$30	$185	$15
D	117%	$220	$110	$20	$30	$250	$15
E	133%	$300	$150	$25	$35	$335	$20
F	159%	$390	$195	$25	$35	$425	$20
G	185%	$535	$270	$35	$45	$580	$30
H	200%	$600	$300	$35	$45	$645	$30
I	250%	$630	$315	$40	$50	$680	$35
Z*	40%	$0	$0	$0	$0	$0	$0

*Z-rating. These are homeless clients living in transitional housing or residing with others. These clients are exempt from client copayments. A homeless person is one who lacks a fixed, regular and adequate night time residence.

PLEASE NOTE: THIS IS NOT AN INSURANCE PROGRAM. THE PIONEERS MEDICAL CENTER FINANCIAL ASSISTANCE PROGRAM APPLIES ONLY TO SERVICES RECEIVED AT PMC AND MEEKER FAMILY HEALTH CENTER. IT DOES NOT APPLY TO:
1. OTHER MEDICAL FACILITIES
2. PHARMACIES
3. PROFESSIONAL FEES FOR SPECIALTY PROVIDERS, EVEN IF THEY PROVIDE SERVICES AT PMC. YOU WILL HAVE TO MAKE FINANCIAL ARRANGEMENTS WITH THAT DOCTOR FOR PAYMENT OF THEIR PROFESSIONAL SERVICES.
4. PATHOLOGY SERVICES (ST. MARY'S, VALLEY VIEW HOSPITAL, ETC)
5. RADIOLOGY SERVICES PROVIDED BY MOUNTAIN RADIOLOGY

Pioneers Medical Center follows the guidelines of the Colorado Indigent Care Program in order to provide a fair and consistent application of the rules and regulations to all patients who are in need of healthcare services.

FINANCIAL ASSISTANCE PROGRAM APPLICATION

NAME_____

ADDRESS_____

CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____

APPLICANT DATE OF BIRTH_____
SOCIAL SECURITY NUMBER OF APPLICANT_____

HOUSEHOLD MEMBERS (include those for whom you provide child support)

_____DOB_____

_____DOB_____

_____DOB_____

_____DOB_____

DOCUMENTATION FOR THE FOLLOWING MUST BE PROVIDED:

GROSS ANNUAL INCOME (Employment, Unearned, Self-Employment)	$_____
CURRENT BALANCE OF CHECKING AND SAVINGS ACCOUNTS	$_____
RENT OR MORTGAGE PAYMENT EXPENSE (12 MONTHS)	($_____)
TOTAL	$_____

RATING_____

NOTES_____

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CLIENT SIGNATURE_____DATE_____

NOTE: THIS IS NOT AN INSURANCE PROGRAM. IT APPLIES ONLY TO PMC AND WILL NOT BE ACCEPTED AT ANY OTHER MEDICAL FACILITY OR PHARMACY. PLEASE INITIAL TO ACKNOWLEDGE:____

FINANCIAL COUNSELOR SIGNATURE_____DATE_____

Internal Use Only:
Rio Blanco County Resident___ Health Insurance Card___
State of Colorado Drivers License/ID Card ___ Medicaid Denial____
Copy of check stubs/tax return or unearned income___
Current CICP card_____ Issuing Facility_____